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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51310 Based on observation, interviews, record review, the facility failed to ensure the call light was within reach for one of four sampled residents (Resident 7). This failure had the potential for increased risk of falls, delayed response to emergencies, and unmet basic needs for Resident 7. Findings: During a review of Resident 7's record titled, Face Sheet (front page of the chart that contains a summary of basic information about the resident), dated 5/22/25, the Face Sheet indicated Resident 7 was admitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities), cerebral vascular accident (CVA - stroke, loss of blood flow to a part of the brain), hypertension (high blood pressure), and generalized muscle weakness. During a review of Resident 7's record titled, Minimum Data Sheet (MDS - a resident assessment tool), dated 3/19/2025, the MDS indicated Resident 7 was dependent on staff for all activities. During a review of Resident 7's records, titled Care Plan Report (CP), dated 4/24/25, the CP indicated, Resident is at risk for falls with or without injury related to antidepressant medication, antihypertensive medication, visual impairment. and Keep call light within reach. During a concurrent observation and interview on 5/21/25 at 3:10 PM with Licensed Vocational Nurse 1 (LVN 1) in Resident 7's room, Resident 7 was in bed and their touch pad call light was hanging behind the resident's head, out of reach. LVN 1 stated that the call light should be in the residents reach to allow the resident to call for assistance and prevent accidents. During an interview on 5/21/25 at 3:13 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated that the call light should be within the resident's reach so they can call for assistance. The resident can fall if they cannot get to the call light. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 4/25, the P&P indicated, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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	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). 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Complete and re-submit the Preadmission Screening and Resident Review ([PASARR - a tool to determine if the person had, or was suspected of having a mental illness, intellectual disability, or related condition) Level one (I) screening and refer one of two sampled residents (Resident 45) who had a diagnosis of major depressive disorder ([MDD] - a mood disorder that causes a persistent feelings of sadness and loss of interest) to the appropriate state-designated authority for PASARR Level two (II) evaluation and determination. This deficient practice had the potential to result in Resident 45 to not receive the appropriate medical treatments for mental illness diagnosis. Findings: During a review of Resident 45's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 45 was admitted to the facility on [DATE]. Resident 45's diagnoses included MDD, 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), and hypertension ([HTN] - high blood pressure). During a review of Resident 45's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 2/6/2025, the MDS indicated, Resident 45's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 45 required substantial assistance (helper does more than half the effort) from staff with upper body dressing and personal hygiene and moderate assistance (helper does less than half the effort) with oral hygiene. During a concurrent interview and record review on 5/21/2025 at 11:47., with the Case Manager (CM), Resident 45's PASARR level I Screening completed by another facility on 11/2/2024, was reviewed. The CM stated the PASARR Level 1 screening indicated, Resident 45 had no serious mental illness diagnosis. The CM stated the PASARR Level 1 screening also indicated, Resident 45's case was closed, and a PASARR level II mental health evaluation was not required. The CM stated she should have completed and resubmitted a new PASARR Level I screening as required by federal regulation based on Resident 45's diagnosis of MDD which was considered as mental illness. The CM stated a positive Level I screening would trigger a Level II mental health evaluation. The CM stated it was important to refer Resident 45 to the state mental health agency to evaluate if the facility could provide her psychiatric (branch of medicine that deals with mental illness) care and treatment. The CM stated there was a possibility that Resident 45's rights to avail for mental health services was denied because the facility did not resubmit the PASARR Level 1 screening. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of PASRR reference manual, dated 2/2023, the PASRR reference manual indicated, An additional requirement has been added for NF's to promptly notify the state mental health and/or intellectual or developmental disability authority, as applicable, if there is a significant change in the physical or mental condition of an individual who is mentally ill or has an intellectual or developmental disability. This would warrant a re-evaluation to determine if a NF is still the most appropriate setting and/or if the individual could benefit from specialized services for his/her mental illness or intellectual disability.

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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** 48712 Based on interview, and record review, the facility failed to: 1. Ensure one of seven sampled residents (Resident 39) received a Pre-Admission Screening and Resident Review ([PASRR] - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) level II assessment. This deficient practice had the potential to result in Resident 39 not receiving the required services for his mental health condition. Findings: During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 39's History and Physical (H&P), dated 4/9/2025, the H&P indicated Resident 39 had the capacity to understand and make medical decisions. During a review of Resident 39's Minimum Data Set ([MDS]- a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 39 was dependent on staff for toileting, showering, and dressing the lower body. During a review of Resident 39's Department of Health Care Services ([DHCS]- a state agency responsible for providing health care to low-income individuals and people with disabilities) letter, dated 4/22/2025, the letter indicated a serious mental illness [NAME] II mental health evaluation was required. During a concurrent interview and record review on 5/22/2025 at 9:14 a.m. with the Medical Records Director (MRD), Resident 39's DHCS letter, dated 4/28/2025 was reviewed. The letter indicated a Level II evaluation was not completed because facility staff were unresponsive to two or more attempts of communication and the case is now closed. The MRD stated she was supposed to resubmit the Level I within a week of receiving the letter but failed to do so. The MRD stated she just resubmitted the Level I today. Since the Level I was not submitted on time, the resident may not have received the psychiatric care he needed. During a review of the facility's policy and procedure (P&P) titled, Admissions Criteria, dated April 2025, the P&P indicated if the level I screen indicates that the individual may meet criteria for a mental disorder they are referred to the state PASARR representative for the Level II screening process.

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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. 48712 Based on interview and record review, the facility failed to: 1. Ensure one of seven sampled residents (Resident 63) had the battery changed in her Life Vest (device that monitors the heart to correct dangerous rhythms) per physician's order. This deficient practice had the potential to result in the battery running out which would prevent monitoring of the resident's heart rhythm. Findings: During a review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was initially admitted to facility on 3/21/2025, with a readmission on 4/13/2025. Resident 63'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 congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 63's History and Physical (H&P), dated 3/22/2025, the H&P indicated Resident 63 had the capacity for medical decision making. During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 63's cognition (ability to think and reason) was moderately impaired. Resident 63 was dependent on staff for toileting, showering, and dressing the lower body. During a review of Resident 63's care plan, dated 4/6/2025, the care plan indicated Resident 63 had a life vest and was at risk for chest pain, dizziness, and palpitations (irregular heartbeat). The care plan indicated the facility would perform Life Vest checks as ordered. During a review of Resident 63's Order Summary, dated 5/23/2025, the summary indicated the physician entered an order on 4/13/2025 for staff to change the Life Vest battery every morning at 6:00 a.m. During an interview on 5/22/2025 at 1:08 p.m. with Licensed Vocational Nurse (LVN) 2, LVN2 stated the night shift did not change the Life Vest battery today at 6:00 a.m. LVN2 stated he did not change the battery today because he only changes it when it beeps. Beeping indicates the battery is running low. LVN2 stated the physician entered the order for the battery to be changed at 6:00 a.m. because it needs to be changed at that specific time. LVN2 stated if the battery runs out Resident 63 might be in distress and no one would know because the machine is not monitoring.

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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. 51310 Based on observation, interview, and record review, the facility failed to ensure the resident's bed was in the low position for one of four sampled residents (Resident 6). This failure had the potential for an increased risk of falls and injuries. Findings: During a review of Resident 6's record titled, Face Sheet (front page of the chart that contains a summary of basic information about the resident), dated 5/22/25, the Face Sheet indicated the facility admitted Resident 6 on 12/18/24 with a diagnoses of dementia (a progressive state of decline in mental abilities), epilepsy (brain disorder that causes a person to have seizures, a sudden surge of electrical activity in the brain that can cause convulsions and a loss of consciousness), unspecified immunodeficiency (condition where the immune system is unable to effectively fight off infections and diseases), dysphagia (difficulty swallowing), repeated falls, and muscle weakness. During a review of the Resident 6's record, titled Physician Order's, dated 5/22/25, the Physician Order's indicated, Fall Precautions (strategies and measures taken to reduce the risk of accidental falls). During a review of Resident 6's record, titled Minimum Data Sheet (MDS - a resident assessment tool), dated 3/19/25, the MDS indicated Resident 6 required partial to moderate assistance with transfers from bed to chair. During a review of Resident 6's records, titled Care Plan Report (CP), dated 2/10/25, the CP indicated, Keep bed in lowest position. During an observation on 5/20/25 at 10:20 AM in Resident 6's room, Certified Nursing Assistant 1 (CNA 1) exited the room and did not lower Resident 6's bed to the lowest position while Resident 6 was in bed. During an interview on 5/20/25 10:22 AM with CNA 1, CNA 1 stated the bed should have been lowered to prevent injury. During a concurrent observation and interview on 5/21/25 at 3:10 PM with Licensed Vocational Nurse 1 (LVN 1) in Resident 6's room, Resident 6's bed was not in the lowest position while Resident 6 was in bed. LVN 1 stated that Resident 6 is under fall precautions which requires keeping the bed in the lowest position and using bilateral floor mats to lessen injury should Resident 6 fall out of bed. During an interview on 05/20/25 10:22 AM with CNA 1, CNA 1 stated the bed should have been lowered to prevent injury. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 9:12 AM with the Director of Nursing (DON), the DON stated resident beds should be in the low position to lessen the harm from falls.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to: 1. Ensure one of seven sampled residents (Resident 42) food was at an appetizing temperature for consumption. This deficient practice resulted in Resident 42 not being able to eat the hard-boiled eggs she requested for breakfast. Findings: 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. During a review of Resident 42's care plan, dated 4/15/2025, the care plan indicated Resident 42 was at risk for a nutritional imbalance. During a concurrent observation and interview on 5/22/2025 at 7:40 a.m. with Resident 42, Resident 42's breakfast tray was noted to contain one hard-boiled egg, toast, and cereal. Resident 42 pointed at the egg and stated, It's cold. I can't eat it when it's cold. Resident 42 stated she gets cold food all the time. During a concurrent observation and interview on 5/22/2025 at 7:45 a.m. with Licensed Vocational Nurse (LVN) 2, LVN2 touched the boiled egg and stated, It's ice cold. It feels like it just came out of the refrigerator. LVN2 stated he would be upset if he was served the egg. LVN2 stated residents need protein for nutrition and it helps them maintain their weight. If the resident can't eat the food she may lose weight. During a concurrent observation and interview on 5/22/2025 at 7:47 a.m. with the Dietary Services Supervisor (DSS), the DSS felt the boiled egg and stated, It's cold, it should be warm. The DSS stated the eggs come from the refrigerator but should be reheated. The DSS stated receiving cold food can affect the resident's food intake and she can have weight loss. During a review of the Dietary Services Supervisor job description, (no date), the job description indicated the DSS would participate in food preparation and service of food that is appetizing and is of the quality to meet each resident's needs.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview and record review, the facility failed to: 1. Ensure one of seven sampled residents (Resident 65) preferences to accommodate her lactose intolerance (digestive issue that results in difficulty digesting the sugar in milk) was honored. This deficient practice resulted in Resident 65 not being able to enjoy milk with her meals. This practice also had the potential to result in Resident 65 experiencing diarrhea, belly pain, or nausea if she consumed the milk that was provided. Findings: During a review of Resident 65's Admission Record, the Admission Record indicated Resident 65 was admitted to the facility on [DATE]. Resident 65's diagnoses included diabetes mellitus ((DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and hyperlipidemia (condition where there is high levels of fat in the blood). During a review of Resident 65's History and Physical (H&P), dated 3/30/2025, the H&P indicated Resident 65 had the capacity for medical decision making. During a review of Resident 65's Dietary Interview/Pre-Screen, dated 3/28/2025, the pre-screen indicated Resident 65's beverage preference was to have Lactaid for breakfast, lunch, and dinner. During a review of Resident 65's care plan, dated 4/6/2025, the care plan indicated the facility would cater to Resident 65's food preferences. During a concurrent observation and interview on 5/21/2025 at 12:30 p.m. with Resident 65, Resident 65's lunch tray contained a carton of low-fat milk. Resident 65 stated she is lactose intolerant. Resident 65 stated milk upsets my stomach. Stated she gets abdominal pain and diarrhea if she drinks the low-fat milk. Resident 65 stated the facility gives her milk every day with every meal although she requested Lactaid. Observation of Resident 65's tray card did not indicate she was lactose intolerant or preferred Lactaid. During an interview on 5/21/2025 at 12:40 p.m. with the Dietary Services Supervisor (DSS), the DSS stated Resident 65 is lactose intolerant. The DSS stated the low-fat milk on Resident 65's tray can cause her to have stomach problems. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, (no date), the P&P indicated each resident has specific food and beverage preferences detailed on a tray card, so accurate diets are served. During a review of the Dietary Services Supervisor job description, (no date), the job description indicated the DSS would check trays for accuracy before they are delivered.

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	055608	A. Building B. Wing	05/23/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48712 Based on observation, interview and record review, the facility failed to: 1. Ensure the emergency dry food storage room had the correct thermometer for accurate temperatures. This deficient practice resulted in inadequate monitoring of food being stored in the room. Findings: During a concurrent observation and interview on 5/21/2025 at 12:37 p.m. with the Dietary Services Supervisor (DSS) in the emergency food dry storage room, a thermometer labeled Cold Food Handling Ref-Freezer Thermometer was noted. The thermometer range was -20 to 70 degrees Fahrenheit (unit of measure for temperature). The thermometer gauge was past the 70 mark. The DSS stated it was not the correct thermometer. The DSS stated the food can be dangerous to give to a resident because you don't know the correct temperature of the room. During a review of the Dietary Services Supervisor job description, (no date), the job description indicated the DSS would maintain the food storage area in a safe manner.

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	055608	A. Building B. Wing	05/23/2025

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 51310 Based on interview and record review, the facility failed to provide meeting minutes and evidence of sufficient governing oversight to demonstrate the maintenance of an effective Quality Assurance and Performance Improvement (QAPI - a data driven proactive approach to improvement used to ensure services are meeting quality standards) Program for the last recertification survey of 2024. This deficient practice resulted in repeat deficiencies in the areas of Resident Assessments and Food and Nutrition Services that could affect the residents' health. Findings: During an interview on 5/23/25 at 10:28 AM with the Administrator (ADM), the ADM stated there was no documentation of QAPI for the past deficiencies in nutrition services and resident assessments. ADM stated that any deficient findings should have been addressed during QAPI meetings to improve the staff and facility. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, dated 4/25, the P&P indicated, The responsibilities of the QAPI committee are to: help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51310 Based on observation, interview, and record review, the facility failed to: 1. Follow enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms) for one of four sampled residents (Resident 6). 2. Ensure Certified Nursing Assistant 1 (CNA 1) performed hand hygiene (the act of cleaning one's hands with soap and water or using an alcohol-based hand sanitizer to remove germs, dirt, and other unwanted substances) before and after performing care for one of four sampled residents (Resident 16). This failure had the potential for an increased risk of developing and spreading life threatening infections to Resident 6, Resident 16, as well as other residents and staff in the facility. Findings: 1.During a review of Resident 6's record titled, Face Sheet (front page of the chart that contains a summary of basic information about the resident), dated 5/22/25, the Face Sheet indicated the facility admitted Resident 6 on 12/18/24 with a diagnoses of dementia (a progressive state of decline in mental abilities), epilepsy (brain disorder that causes a person to have seizures, a sudden surge of electrical activity in the brain that can cause convulsions and a loss of consciousness), unspecified immunodeficiency (condition where the immune system is unable to effectively fight off infections and diseases), dysphagia (difficulty swallowing), repeated falls, and muscle weakness. During a review of Resident 6's record titled, Minimum Data Sheet (MDS - a resident assessment tool), dated 3/19/25, the MDS indicated Resident 6 required partial to moderate assistance with transfers from bed to chair. During a review of Resident 6's record titled, History and Physical (H&P - a comprehensive evaluation of a patient's health, including a thorough medical history and a physical examination), dated 1/13/25, the H&P indicated the resident had a gastric tube (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's record titled, Physician Orders (PO), dated 5/22/25, the PO indicated Enhanced Barrier Precautions. During an observation on 05/20/25 at 10:20 AM in Resident 6's room, CNA 1 was not wearing a gown while shaving Resident 6, under EBP. During an interview on 5/20/25 at 10:25 AM with CNA 1, CNA 1 stated they should have worn a gown while administering care to Resident 6. (continued on next page)

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	055608	A. Building B. Wing	05/23/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 9:12 AM with the Director of Nursing (DON), the DON stated that staff need to wear a gown and gloves when performing care for residents under EBP to prevent the spread of infections. During an interview on 5/22/25 at 10:37 AM with the Infection Preventionist Nurse (IPN - a healthcare professional who works to prevent the spread of infections in the healthcare setting), the IPN stated EBP is practiced on residents that have a medical device like a G-tube, foley catheter (a thin, flexible tube inserted into the bladder to drain urine) or have a wound. The IPN stated that when providing care for residents under EBP, staff are supposed to wear gloves, mask, and gown to protect the residents from acquiring and spreading multidrug resistant organisms (MDRO - is a germ that is resistant to many antibiotics). 2. During a review of Resident 16's record, titled, Face Sheet (front page of the chart that contains a summary of basic information about the resident), dated 5/23/25, the Face Sheet indicated the facility admitted Resident 16 on 5/5/25 with a diagnoses of dementia, epilepsy, and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 16's record, titled, Minimum Data Sheet (MDS - a resident assessment tool), dated 4/17/25, the MDS indicated Resident 16 was dependent on staff for all activities. During an observation on 5/23/25 at 8:04 AM in Resident 16's room, After CNA 1 fed Resident 16, CNA 1 walked out of the room without performing hand hygiene, CNA 1 obtained a cup from the medication cart and returned to the room and did not perform hand hygiene prior to restarting to feed Resident 16. During an interview on 5/23/25 at 8:07 AM with CNA 1, CNA 1 stated, Oh, I forgot. CNA 1 stated that they are required to perform hand hygiene before and after entering the resident's room to prevent the spread of infections. During an interview on 5/23/25 at 12:08 PM with the IPN, the IPN stated staff are supposed to wash or perform hand hygiene before and after entering the room, to prevent the spread of infections. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 4/25, the P&P indicated, Enhanced barrier precautions apply when: A resident is NOT to be infected with or colonized with any MDRO, has a wound or indwelling medical devices. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 4/25, the P&P indicated, Hand hygiene is indicated: immediately before touching a resident; after touching a resident; after touching the resident's environment; immediately after glove removal.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review. The facility failed to: 1. Complete the McGeer Criteria (minimum set of signs and symptoms which when met, indicated that a resident likely has an infection and that an antibiotic (a drug used to treat infections caused by bacteria) might be needed) for Infection Screening Evaluation for one of two sampled residents (Resident 13). This deficient practice had the potential to result in the development of multi-drug-resistant organisms ([MDRO] - microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents) from inappropriate antibiotic use. Findings: 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 Minimum Data Assessment ([MDS] - a resident assessment tool), 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 Physician Order, dated 12/16/2024, the Physician Order indicated, Resident 13 had an order to give Clindamycin hydrochloride (an antibiotic used to treat many different types of infection caused by bacteria) 600 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) every 8 hours until 12/19/2024 for sacral (the triangular-shaped bone at the base of the back) wound infection. During a concurrent interview and record review on 5/20/2025 at 2:28 p.m., with the Infection Preventionist Nurse (IPN), Resident 13's clinical records were reviewed. The IPN stated she did not complete and fill out Resident 13's McGeer Criteria Infection Screening Evaluation form within 3 days after the antibiotic was ordered. The IPN stated McGeer Criteria Infection Screening Evaluation form was a guide to determine if the resident meets the criteria for the use of antibiotic as prescribed by the physician. The IPN stated she could not validate Resident 13's antibiotic was appropriate and would put her at risk for MDRO since she did not complete the McGeer Criteria Infection Screening Evaluation form. (continued on next page)

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	055608	A. Building B. Wing	05/23/2025

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F 0881 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, Surveillance for Infections, dated 4/2025, the P&P indicated, The infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The P&P indicated the criteria for such infections are based on the current standard definitions of infections.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 47923 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet ([sq. ft.] unit of measurement) per resident in multiple resident bedrooms for six out of 30 resident rooms. The insufficient space had the potential to result in and lead to inadequate nursing care to the residents. Findings: During a facility tour on 5/23/2025 at 8:10 a.m., it was observed that residents in Rooms 1, 2, 3, 5, 22 and 31 were able to move in and out of their rooms, and there was space for the beds, side tables, and resident care equipment. During an interview on 5/232025 at 8:25 a.m., with the Maintenance Supervisor (MS), the MS confirmed they had resident rooms with less than the required 80 sq. ft. per resident. The facility's letter requesting a Room Size Waiver, dated 5/22/2025, submitted by the Administrator (ADM), for 6 resident rooms was reviewed. The waiver request letter indicated that there were sufficient space for wheelchair and other medical equipment, as well as space for ambulatory and non-ambulatory residents to move freely without harm or impediment and all rooms will continue to maintain privacy standards and promote a home like environment while continuing to maintain infection control and safety standards. The following room provided less than 80 sq. ft. per resident: Rooms # beds sq. ft 1 3 212.00 2 3 227.00 3 4 280.00 5 4 286.00 22 3 181.00 31 4 269.00 During a review of the facility's policy and procedure (P&P) titled, Bedrooms, dated 4/2025, the P&P indicated, Bedrooms measure at least 80 square feet of usable living space per resident in double rooms and at least 100 square feet of usable living space in single rooms.