

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Osage Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Osage Ave Inglewood, CA 90301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility failed to ensure a Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for one of three sampled residents (Resident 1) by failing to: 1. Ensure Resident 1's hearing aid (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty of hearing) was encoded and assess her hearing ability properly. This deficient practice had the potential to negatively affect the plan of care and delivery of care services for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of left femur (a break, crack, or crush injury in the bone of the left thigh), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and dysphagia (difficulty of swallowing). During a review of Resident 1's History and Physical (H&P), dated 11/17/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review Resident 1's MDS assessment, dated 10/29/2025, the MDS assessment indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 1 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and lower body dressing. During a review of Resident 1's Social Services Assessment, dated 10/27/2025, the Social Services Assessment indicated, Resident 1 has right and left hearing aid. During a concurrent interview and record review on 2/4/2026 at 11:43 a.m., with the Minimum Data Set Nurse (MDSN), Resident 1's MDS assessment, dated 10/29/2025, was reviewed. The MDSN stated MDS Section B (Hearing, Speech, and Vision) look back period (the specific time frame within which certain resident conditions and events are assessed) was 7 days before the completion date. The MDSN stated Resident 1's MDS assessment was completed inaccurately. The MDSN stated Resident 1's MDS, Section B0200 (Hearing) was coded 0 (Adequate), however, it should have been coded as 1 (Minimal difficulty). The MDSN stated Resident 1's MDS, Section B0300 (Hearing Aid) was coded 0 (No), however, it should have been coded as 1 (Yes). The MDSN stated she did not see Resident 1's using her hearing aid at the time of the MDS assessment on 10/29/2025. The MDSN stated she did not follow the Resident Assessment Instrument ([RAI] - a standardized tool used in nursing homes and long-term care facilities to assess resident's needs, strengths, and potential risks) Section B guidelines in completing the MDS assessment. The MDSN stated MDS assessment reflects resident's present condition and facility's plan of care. The MDSN stated if the MDS assessment was not completed accurately then the facility won't be able to provide quality of care to residents. During an interview on 2/4/2026 at 12:15 p.m., with the Director of Nursing (DON), the DON stated MDS assessment should be completed accurately to meet the needs of the resident and for the facility to develop appropriate plan of care for the residents. During a review of the facility's policy and procedure (P&P) titled, RAI Process, dated 10/4/2016, the P&P indicated, To</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056143	Facility ID: 056143 If continuation sheet Page 1 of 6

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. During a review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page B-2, under Steps for Assessment, indicated number 1. Ensure that the resident is using their normal hearing appliance if they have, 5. Review the medical record, 6. Consult the resident's family, caregivers, direct care staff, activities personnel, and speech or hearing specialist. During a review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page B-5, under Steps for Assessment, indicated number 1. Prior to beginning the hearing assessment, ask the resident if they own a hearing aid or other hearing appliance and if so, whether it is at nursing home, 4. Check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered care plan for one of one sampled resident (Resident 1) by failing to: 1. Develop a comprehensive care plan addressing Resident 1's missing right hearing aid. This deficient practice had the potential to result in a lack of meeting necessary care and addressing medical needs for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of left femur (a break, crack, or crush injury in the bone of the left thigh), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and dysphagia (difficulty of swallowing). During a review of Resident 1's History and Physical (H&P), dated 11/17/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review Resident 1's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 10/29/2025, the MDS assessment indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 1 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and lower body dressing. During a review of Resident 1's Theft/Loss Report, dated 11/21/2025, the Theft/Loss Report, indicated Resident 1 had missing right hearing aid. During a concurrent interview and record review on 2/4/2026 at 11:23 a.m., with Registered Nurse 1 (RN 1), Resident 1's care plans were reviewed. RN 1 stated there was no comprehensive care plan to address Resident 1's missing right hearing aid. RN 1 stated care plan is a communication tool among interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) that has a problem, goal, and interventions. RN 1 stated failure to develop a care plan would result in lack of resident's continuity of care. During an interview on 2/4/2026 at 11:50 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated development of care plan is a consolidated team effort. The MDSN stated the IDT should develop care plan to address any resident's problem or concerns identified to come up with a goal and interventions. During an interview on 2/4/2026 at 12:17 p.m., with the Director of Nursing (DON), the DON stated care plan serves as a guidance on how to care properly of the residents. The DON stated it is important to develop a comprehensive care plan in order to provide appropriate care to each resident. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure audiology (branch of science and healthcare focused on the study, diagnosis, treatment, and prevention of hearing, balance, and related auditory disorders in patients of all ages) consultation appointment was provided in a timely manner for one of one sampled resident (Resident 1). This deficient practice had the potential for Resident 1's deterioration of hearing that could negatively affect her quality of life. Findings: During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of left femur (a break, crack, or crush injury in the bone of the left thigh), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and dysphagia (difficulty of swallowing). During a review of Resident 1's History and Physical (H&P), dated 11/17/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review Resident 1's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 10/29/2025, the MDS assessment indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 1 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and lower body dressing. During a review of Resident 1's Social Services Assessment, dated 10/27/2025, the Social Services Assessment indicated, Resident 1 has right and left hearing aid. During a review of Resident 1's Theft/Loss Report, dated 11/21/2025, the Theft/Loss Report, indicated Resident 1 had missing right hearing aid. During a review of Resident 1's Initial Ears, Nose, and Throat (ENT) Consultation Report, dated 12/22/2025, the ENT Consultation Report indicated, Resident 1 had a hearing loss and Resident 1 previously wore hearing aids but stopped wearing them since she lost her left hearing aid. The ENT Consultation Report indicated, Resident 1 was recommended to undergo audiogram (hearing test) for further assessment. During a review of Resident 1's Order Summary Report (a document containing active orders) dated 2/4/2026, the Order Summary Report indicated, the physician placed a telephone order on 11/14/2025 for Resident 1 to have audiology consultation with follow-up treatment as indicated. During an interview on 2/4/2026 at 8:45 a.m., with Resident 1, Resident 1 stated she lost her hearing aids. Resident 1 stated sometimes she gets upset when she could not hear well especially when staff talks to her. During an interview on 2/4/2026 at 10:45 a.m., with the Social Service Director (SSD), the SSD stated Resident 1's right hearing aid was reportedly missing on 11/21/2025. The SSD stated Resident 1 was seen by the ENT doctor on 12/22/2025 and recommended to have audiogram. The SSD stated Resident 1 had an audiogram on 1/30/2026, 39 days after it was recommended by the ENT doctor. The SSD stated it is her responsibility to schedule an audiogram appointment for Resident 1. The SSD stated Resident 1 should have been referred for audiogram within 7 days after it was recommended. The SSD stated it is important to refer Resident 1 immediately for audiology consult to prevent further decline in hearing loss. The SSD stated further hearing loss could result in miscommunication and depression that would diminish resident's quality of life. During an interview on 2/4/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated Resident 1 should have been referred to the audiologist for audiogram as soon as they found out about the missing right hearing aid. The DON stated Resident 1 would suffer more for not being able to hear well and at risk for social isolation. During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Quality of Life, dated 3/2017, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. During a review of the facility's P&P titled, Care of Deaf or Hearing-Impaired Resident, dated 1/1/2012, the P&P indicated, Social Services will refer the resident to an audiologist if indicated. During a review of the facility's Social Service Coordinator Job Description, the Social Service Coordinator Job Description indicated, one of the principal responsibilities of the Social Service Coordinator is to arrange ancillary services that have been determined necessary to maintain the resident's concrete needs.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure an inventory of personal belongings was signed by resident or resident representative and facility staff and copy was provided for one of one sampled resident (Resident 1). This deficient practice had the potential for not having proper accountability of Resident 1's personal belongings. Findings: During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included fracture of left femur (a break, crack, or crush injury in the bone of the left thigh), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and dysphagia (difficulty of swallowing). During a review of Resident 1's History and Physical (H&P), dated 11/17/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review Resident 1's Minimum Data Set ([MDS] a resident assessment tool) assessment, dated 10/29/2025, the MDS assessment indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment indicated, Resident 1 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and lower body dressing. During a concurrent interview and record review on 2/4/2026 at 9:55 a.m., with Registered Nurse 1 (RN 1), Resident 1's Personal Effects Inventory Form, dated 10/23/2025, was reviewed. RN 1 stated Resident 1's Personal Effects Inventory form was not signed by resident or her representative and facility's staff upon Resident 1's admission to the facility. RN 1 stated Resident 1's representative was not given a copy of the initial admission resident inventory form. RN 1 stated resident's Personal Effects Inventory Form should be completed upon admission, readmission and as needed. RN 1 stated the Personal Effects Inventory Form is a tracking tool to monitor resident's personal belongings that was brought to the facility. RN 1 stated lost personal item could potentially cost to the facility management. RN 1 stated it has never been a practice by the facility to inform and provide a copy to resident's representative of what personal items that were brought by resident from the hospital. RN 1 stated resident's Personal Effects Inventory Form is part of resident's medical records and should be completed accurately. RN 1 stated it is important to have completeness of medical records for transparency and for continuity of care. During an interview on 2/4/2026 at 11:00 a.m., with the Social Service Director (SSD), the SSD stated it is important to properly document and signed the Personal Effects Inventory form for the personal items brought by resident to the facility for safekeeping. During an interview on 2/4/2026 at 12:05 p.m., with the Director of Nursing (DON), the DON stated facility staff, and resident representative should sign the Personal Effects Inventory Form, and a copy should be provided to the resident representative for verification of resident's personal items. The DON stated by not completing and signing the Personal Effects Inventory Form, there would be a risk for missing or lost personal items and possible theft. The DON stated incomplete medical records could possibly result in not meeting resident needs. During a review of the facility's policy and procedure (P&P) titled, Personal Property, dated 11/14/2025, the P&P indicated, The personal property inventory form will be signed and placed in the medical record. The P&P also indicated a copy of the written inventory shall be provided to the resident/resident representative. During a review of the facility's P&P titled, Completion and Correction, dated 1/1/2012, the P&P indicated, To ensure that medical records are complete and accurate.</p>		