STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to: 1. Provide continuous supplemental oxygen (a medical treatment delivering oxygen enriched air to people with breathing problems) at two liters per minute (lpm, unit of measurement the rate of oxygen flow delivered to the resident) through nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as ordered by the physician for one of three sampled residents (Resident 2). 2. Ensure the oxygen tubing (a flexible, latex-free tubing, to deliver oxygen from a source) was labeled and dated for one of three sampled residents (Resident 22). 3. Implement the facility's policies and procedures to replace the filter of the BiPAP machine (Bilevel positive airway pressure - a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) every two weeks for one of two sampled residents. (Resident 30) These failures had the potential for Resident 2, Resident 30, and Resident 22 to experience respiratory distress (significant difficulty breathing, where the body struggles to get enough oxygen) and worsening respiratory conditions that may lead to avoidable hospitalization. Findings: 1. During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 2 on 11/14/2019 with diagnoses including heart failure (a disorder which causes the heart to not pump the blood efficiently), history of cerebral infarction (stroke, loss of blood flow to a part of the brain due to blockage), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 2 experiences shortness of breath lying flat and requires oxygen therapy while a resident in the facility. During a review of Resident 2's Care Plan Report, dated 9/15/2025 indicated an intervention of Administer oxygen settings: Oxygen at 2 lpm via [nasal cannula] to keep [oxygen saturation] above 95% every shift for [shortness of breath] was started on 12/17/202. During an observation on 2/11/2026 at 9:07 a.m. in the facility hallway, Resident 2 was observed sitting on a wheelchair beside an oxygen concentrator (a medical device that extracts, filters and concentrates oxygen from surrounding air). Resident 2 was not wearing nasal cannula or oxygen mask. During a concurrent observation and interview on 2/11/2026 at 10:01 a.m. with Licensed Vocational Nurse (LVN) 1 in the facility hallway, Resident 2 was observed not wearing a nasal cannula or oxygen mask beside an oxygen concentrator. LVN 1 stated Resident 2 should be on supplemental oxygen through nasal cannula as ordered by the physician. During a concurrent interview and record review on 2/12/2026 at 2:20 p.m. with the Director of Nursing (DON), Resident 2's Physician Order, dated 11/25/2025, was reviewed. The DON stated Resident 2 has an order for continuous supplemental oxygen of 2 lpm via nasal cannula to keep oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage) above 95% for symptoms of shortness of breath. During an interview on 2/13/2026 at 8:13 a.m. with the DON. The DON stated Resident 2 started receiving oxygen therapy for episodes of shortness of breath and had a recent hospitalization for the same reason. The DON stated Resident 2's health may be at risk if physician's order to administer oxygen was not being followed. The DON stated Resident 2 may experience respiratory distress and shortness of breath that may lead to avoidable re-hospitalization. During a review of the facility's policies and procedures (P&P), titled Oxygen Therapy, dated 10/31/2025. The (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P indicated administer oxygen and obtain oxygen saturation levels as ordered by the provider and oxygen will be initiated with a provider order. 2. During a review of Resident 22's admission Record, the admission Record indicated the facility admitted Resident 22 on 12/26/2025 with diagnoses including respiratory failure with hypoxia (inadequate oxygen), dementia (a progressive state of decline in mental abilities) and history of cerebral infarction (stroke). During a concurrent observation and interview on 2/11/2026 at 9:56 a.m. with LVN 1 in Resident 22's room. Resident 22's oxygen tubing did not have a label or date when it was last changed. LVN 1 stated oxygen tubing should be replaced every seven days and should have a label that indicates when it was last changed. LVN 1 stated labeling oxygen tubing was important to ensure staff are aware when it was last changed, the oxygen tubing may have been clogged with nasal drainage, or the integrity of the tubing was compromised, and the residents are not receiving the correct supplemental oxygen ordered by the physician. During an interview on 2/12/2026 at 2:11 p.m. with the Director of Nursing (DON). The DON stated licensed nurses are expected to change oxygen tubing once a week and label the tubing with the date, time, and the name of the staff that completed the task. The DON stated labeling the oxygen tubing will ensure that the tubing was changed, to ensure the tubing is free from debris or kinks and residents would not receive enough oxygen that causes respiratory distress. During a review of the facility's P&P, titled Oxygen Therapy, dated 10/31/2025. The P&P indicated Oxygen equipment shall be maintained as follows: The tubing and mask should be changed at least every seven days and labeled with the date change. 3. During a review of Resident 30's admission Record, the admission Record indicated the facility admitted Resident 30 on 11/18/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), respiratory failure with hypoxia and hypercapnia (excessive buildup of carbon dioxide), heart failure and obstructive sleep apnea (a condition throat muscles relax excessively during sleep causing airway to collapse). During a review of Resident 30's Physician Orders, dated 11/22/2025, the Physician Orders indicated BiPAP Frequency: at bedtime when sleeping and [as needed]. During a concurrent observation and interview on 2/10/2026 at 10:03 a.m. with Resident 30 in the resident's room. A BiPAP machine on the bedside table was observed. Resident 30 stated she uses the BiPAP machine at night when she sleeps and has been using it for several months. During a concurrent observation and interview on 2/12/2026 at 8:02 a.m. with LVN 1 in Resident 30's room. LVN 1 stated he was not aware where the filter system of the BiPAP machine was located. During a concurrent interview and record review on 2/12/2026 at 8:22 a.m. with the DON. Resident 30's Medication Administration Record (MAR) was reviewed. The DON stated there was no documentation that the filter system of Resident 30's BIPAP machine was replaced. The DON stated no one has been responsible for this task and the facility does not have a filter replacement. The DON stated the filter of the BiPAP machine should be replaced every two weeks. The DON stated Resident 30 may inhale particles when using the BIPAP machine that may lead to respiratory infection and worsen current respiratory condition. During a review of facility's P&P, titled BiPAP and CPAP, dated 10/17/2019. The P&P indicated [BiPAP] filters are foam, disposable paper and bacterial filters and cleaning instructions includes but not limited to filters should be changed every 2 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident food brought from outside was labeled, dated and stored in the designated resident's refrigerator in the activity room for one of one sampled resident (Resident 30). 2. Ensure 1 week old lettuce in a clear container was labeled and dated in the vegetable refrigerator in the kitchen. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (an infection or irritation of the gastrointestinal tract caused by eating or drinking food or beverages contaminated with harmful bacteria, viruses, parasites, or chemicals). Findings: 1. During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included obstructive sleep apnea ([OSA] – a common, serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep), chronic obstructive pulmonary disease ([COPD] – a chronic lung disease causing difficulty in breathing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 30's History and Physical (H&P), dated 11/21/2025, the H&P indicated, Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set ([MDS] – a resident assessment tool), dated 11/25/2025, the MDS indicated, Resident 30's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 30 required setup assistance (helper assists only prior to or following the activity) from with eating and oral hygiene. During an interview on 2/11/2026 at 9:07 a.m., with Resident 30, Resident 30 stated her family brought her one bottle of Italian dressing and 1 jar of Hamburger Dill Chips one month ago. During a concurrent observation and interview on 2/11/2026 at 9:17 a.m., with the Dietary Service Supervisor (DSS), in Resident 30's room. The DSS stated there were one bottle of opened Italian dressing and 1 jar of opened Hamburger Dill Chips with no date and label. The DSS stated the opened Hamburger Dill Chips are perishable and should be kept in the resident's refrigerator in the activity room. The DSS stated opened Hamburger Dill Chips when not refrigerated could spoil easily and potentially harm the resident. The DSS stated resident's food brought from outside should be labeled with resident's name, the date received, and the date opened. The DSS stated she does not know who brought Resident 30's outside food. During an interview on 2/11/2026 at 10:48 a.m., with the Director of Nursing (DON), the DON stated all resident's food brought from outside should be labeled and kept in the resident's refrigerator in the activity room especially the perishable food items because of the risk of foodborne illness. During a review of the facility's policy and procedure (P&P) titled, Food Brought in by Visitors, dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/22/2025, the P&P indicated, The facility staff will place the food in a food container that is clearly labeled with the resident's name and date received and stored in the refrigerator. 2. During a concurrent observation and interview, of the initial kitchen tour, on 2/10/2026 at 8:45 a.m., with the Dietary Services Supervisor (DSS), a large clear Tupperware container with 6 heads of lettuce was noted in the vegetable refrigerator without a date label. The DS stated the lettuce was approximately 1 week old. The DS stated food items in the refrigerator were required to have an open and used by date. The DS stated the risk of not labeling the dates on the lettuce container could result in residents consuming possibly expired food. During a review of the facility's policy and procedures (P&P), titled Food Storage and Handling, dated 6/4/2024, the P&P indicated all food items were to be correctly labeled and dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Obtain a written informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from interdisciplinary team (([IDT] - team members from different disciplines who come together to discuss resident care) before initiation of a psychotropic drug (Any drug that affects brain activities associated with mental process and behavior) for resident with diagnosis of dementia (a progressive state of decline in mental abilities) for one of six sampled residents (Resident 39).This deficient practice placed Resident 39 at risk for sustaining adverse effects (undesired effect of a drug) from psychotropic medication. Findings:During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included dementia (a progressive state of decline in mental abilities), legal blindness (severe vision loss), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 39's History and Physical (H&P), dated 10/10/2025, the H&P indicated, Resident 39 did not have the capacity to understand and make decisions.During a review of Resident 39's Neuropsychiatric (branch of medicine that deals with the diagnosis, treatment, and prevention of mental disorders) Progress Note, dated 12/15/2025, the Neuropsychiatric Progress Note indicated, Resident 39 suffered from dementia and cognitive (ability to think and reason) communication deficit (lack or impairment in function) and any recommendations are subject to the approval of the interdisciplinary team (([IDT] - team members from different disciplines who come together to discuss resident care).During a review of Resident 39's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/15/2026, the MDS indicated, Resident 39's cognitive skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 39 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 39's Order Summary Report (a document containing active orders), dated 2/12/2026, the Order Summary Report indicated, the physician placed a telephone order on 2/5/2026 for Resident 39 to start on Olanzapine (anti-psychotic medication used to treat severe mental health conditions) 5 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to give one tablet at bedtime (9 p.m.) for schizophrenia manifested by disorganized speech and thought processes. The Order Summary Report indicated, Resident 39 was incapable of making healthcare decisions due to dementia.During a review of Resident 39's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 2/6/2026 to 2/11/2026, the MAR indicated, Resident 39 was given Olanzapine 5 mg one tablet at bedtime (9 p.m.).During a concurrent interview and record review on 2/12/2026 at 1:14 p.m., with the Director of Nursing (DON), Resident 39's Psychotherapeutic Drug Informed Consent Form, dated 2/5/2026 was reviewed. The Psychotherapeutic Drug Informed Consent Form indicated, Resident 39, is on Olanzapine 5mg daily for schizophrenia manifested by disorganized speech and thought processes. The DON stated, Resident 39's informed consent for Olanzapine was not signed by the IDT. The DON stated Resident 39 lacks capacity to give informed consent because she has a diagnosis of dementia. The DON stated there were no IDT meeting that were completed before the initiation of Resident 39's psychotherapeutic drug. The DON stated long term use of psychotherapeutic drug can cause adverse reaction such as dizziness and other cardiovascular (heart) complications that would impair resident's health and safety.During a review of the facility's Policy and Procedure (P&P) titled, Informed Consent, dated 1/30/2026, the P&P indicated, If the resident lacks capacity to provide informed consent and does not have a surrogate decision-maker, the facility will convene a Surrogate interdisciplinary team (IDT). The P&P indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the licensed nurse will confirm that the healthcare practitioner obtained informed consent and will document the verification in the resident's medical record, before administering the first dose of psychoactive medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
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** Based on observation, interview, and record review, the facility failed to: 1.Ensure that one of five residents, Resident 35, was provided a call device within their reach. This failure had the potential to result in Resident 35's inability to notify staff when in need of care or in distress.Findings: During a review of Resident 35's admission Record, dated 7/10/2025, the admission Record indicated that Resident 35 has Dementia (decline in memory, thinking, and reasoning) and Dysphagia (difficulty swallowing), Lack of Coordination, and Generalized Muscle Weakness. During a review of Resident 35's History & Physical, dated 7/14/2025, the History & Physical indicated that Resident 35 does not have the capacity to understand and make decisions. During a review of Resident 35's Order Summary Report, dated 7/10/2025, the Order Summary Report indicated Resident 35's discharge potential as poor and that Resident 35 was ordered to receive skilled occupation therapy services (specialized services to improve, restore, or maintain the ability to perform daily living activities) every day, three times a week, for four weeks, for generalized weakness using therapeutic exercise, and therapeutic activities. During an observation on 2/10/2026, at 12:11 p.m., in room [ROOM NUMBER]A, Resident 35 was sitting in a wheelchair at the doorway of their room. The call alert device was on Resident 35's bed, approximately 3 feet behind Resident 35, and there were no facility staff in the room with Resident 35. During an interview on 12/10/2026, at 12:13 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated that Resident 35 would not be able to call for help. CNA 2 stated it's not safe for residents to not have a call alert device available, they should be close to the call device or around others to see them. During an interview on 2/13/2026 at 8:03 a.m., with the Director of Nursing (DON), the DON stated that the call alert device should be in reach of the resident, if not, the resident would not be able to call for assistance. The resident could fall, have a health crisis, or not receive the needed attention. During a record review of P-NP29 Communication-Call System policy, undated, the P-Np29 Communication-Call System policy indicated that the call alert device will be placed within the resident's reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Notify the physician for one of one sampled resident (Resident 30) refusing Bilevel Positive Airway Pressure ([BIPAP] - a noninvasive, mask-based ventilation device that assists with breathing by delivering two distinct levels of pressure) treatment.This failure had the potential for Resident 30 to experience severe shortness of breath that would likely require hospitalization.Findings:During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included obstructive sleep apnea ([OSA] - a common, serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of Resident 30's History and Physical (H&P), dated 11/21/2025, the H&P indicated, Resident 30 had the capacity to understand and make decisions.During a review of Resident 30's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/25/2025, the MDS indicated, Resident 30's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 30 required setup assistance (helper assists only prior to or following the activity) from with eating and oral hygiene.During a review of Resident 30's Order Summary Report (a document containing active orders), dated 2/11/2026, the Order Summary Report indicated, the physician placed a telephone order on 11/21/2025 for Resident 30 to start on BIPAP with Inspiratory Positive Airway Pressure ([IPAP] - higher pressure setting) of 18/5 centimeter ([cm] - unit of measurement) of H2O (water), Fraction of Inspired Oxygen ([FiO2] - the percentage or concentration) of 28 percent ([%]- unit of measurement) with full face mask size 18, at bedtime when sleeping and as needed.During a concurrent interview and record on 2/11/2026 at 10:10 a.m., with the Minimum Data Set Nurse (MDSN), Resident 30's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from January 1, 2026, to 2/11/2026, was reviewed. The MDSN stated Resident 30 was non-compliant and refused BIPAP treatment on 1/3/2026, 1/4/2026, 1/10/2026, 1/23/2026, 1/24/2026, 2/5/2026, and 2/8/2026. The MDSN stated the physician was not notified of Resident 30's refusal for BIPAP treatment. The MDSN stated when resident refused treatment as ordered by the physician, the physician should be notified because it is considered as a resident's change of condition. The MDSN stated Resident 30's refusal to have BIPAP treatment would put her at risk for shortness of breath.During an interview on 2/11/2026 at 10:52 a.m., with the Director of Nursing (DON), the DON stated it is important to notify the physician when a resident refuses treatment so the physician would be aware and make some treatment adjustment and provide intervention.During a review of the facility's policy and procedure (P&P) titled, Refusal of Treatment, dated 1/1/2012, the P&P indicated, The attending physician will be notified of refusal of treatment in a timeframe determined by the resident's condition and potential serious consequences of the refusal.During a review of the facility's P&P titled, Change of Condition Notification, dated 8/25/2022, the P&P indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Inform a resident of how to file a grievance for missing glasses for one of four sampled residents (Resident 32). This deficient practice had the potential to violate the resident's right to have a grievance filed and ensure resident was comfortable at the facility. Findings: During a review of Resident 32's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated Resident 32's diagnoses' list included glaucoma (an eye condition that damages the optic nerve), cataracts (a cloudy or foggy area that develops in the lens of the eye, which is normally clear), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness, numbness, or reduced movement on one side of the body). During a review of Resident 32's History and Physical (H&P) form, dated 9/5/2025, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/17/2025, the MDS indicated Resident 32's cognitive (thinking) skills were cognitively intact. The MDS also indicated Resident 32 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview, on 2/10/2026 at 9:24 a.m., with Resident 32, Resident 32 stated she had been wearing prescription eyeglasses since she was 8 years old. Resident 32 stated she had eyeglasses upon admission, and her eyeglasses were misplaced sometime during a room change. Resident 32 stated she informed the social worker and the Director of Nursing (DON) of her missing eyeglasses but was not informed on how to file a grievance. Resident 32 stated she had blurry vision due to not wearing her eyeglasses which resulted in her feeling frustrated. During an interview, on 2/12/2026 at 8:55 a.m., with the DON, the DON stated the protocol for filing a grievance was to inform all residents that if an issue arises, all resident had a right to file a grievance with a staff member. The DON stated after a resident files a grievance, the grievance would had been given to the Social Services Director (SSD) to follow up on any concerns. The DON stated all staff members can inform a resident on how to file a grievance. The DON stated Resident 32 informed her of her missing eyeglasses a week prior and the night before. The DON stated she did not inform Resident 32 on how to file a grievance. The DON stated the risk of not informing a resident on how to file a grievance could result in a delay in necessary care and services. During a review of the facility's policy and procedures (P&P), titled Grievances, dated 11/14/2025, the P&P indicated, When a Facility Staff member overhears or receives a grievance/complaint from a resident, a resident representative, or family member, the Facility Staff member encourages and offers to facilitate the completion of a Grievance/Complaint Investigation Report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
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** Based on interview and record review the facility failed to: 1. Ensure one of two residents (Resident 2) Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level 1 screening (a mandatory preliminary screening required for all individuals seeking admission to a Medicaid-certified nursing facility) indicated diagnosed mental illnesses. This failure had the potential for Resident 2 not being appropriately identified for further evaluation of serious mental illness leading to resident not receiving necessary specialized services, treatment planning interventions, or appropriate placement.Findings: During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 2 on 9/11/2019 and was readmitted on [DATE] with diagnoses including schizoaffective disorder [a serious, long-term mental health condition that combines symptoms of schizophrenia (psychosis - a mental health condition that causes a person to lose touch with reality) and mood disorders], major depressive disorder (a state of low mood, irritability, or loss of interest in activities lasting at least two weeks that significantly interferes with a person's life), psychotic disorder with delusions (a serious mental health condition where a person loses touch with reality and has a very hard time telling the difference between what is real and what is not), and anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry that goes beyond normal nervousness). During a review of Resident 2's History and Physical (H&P) dated 9/18/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 2 had severe cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 2 was dependent on staff with oral, toileting and personal hygiene, showering, upper and lower body dressing, and putting or taking off footwear. The MDS indicated Resident 2 had active diagnoses of anxiety disorder, depression, and psychotic disorder. During a review of Resident 2's PASARR level 1 screening dated 3/15/2024, the PASARR indicated Resident 2 did not have a serious diagnosed mental disorder. During a concurrent interview and record review on 2/11/2026 at 1:35 p.m. with Medical Records Assistant (MRA), Resident 2's PASARR level 1 screening was reviewed. The MRA stated he should have accurately documented Resident 2's mental health diagnoses. The MRA stated if the mental health diagnoses were not included in the PASARR level 1 screening, the resident would not have received the appropriate services or treatment. During an interview on 2/12/2026 at 3:10 p.m. with the Director of Nursing (DON), the DON stated the importance of documenting the resident's mental health diagnoses was to ensure a level 2 evaluation (an in-depth, person-centered assessment triggered when a level 1 screen suspects a serious mental illness, intellectual disability, or related condition in nursing facility applicants) was completed to indicate recommendations to help develop plan of care. The DON stated if the PASARR level 1 screening was not completed accurately, there would be potential for the resident to not receive the appropriate treatment in the facility. During a review of the facility's policy and procedure (P&P) titled P-NP04 admission Screening Resident Review (PASRR) revised 4/14/2025, indicated .5. The Facility MDS Coordinator will be responsible for accessing and sure updates to the PASRR are completed per MDS guidelines (e.g Significant Change of Statues MDS).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
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 develop a person-centered care plan for one of 17 sampled residents (Resident 30) by failing to: 1. Develop a comprehensive care plan addressing Resident 30's refusal to use Bilevel Positive Airway Pressure ([BIPAP] - a noninvasive, mask-based ventilation device that assists with breathing by delivering two distinct levels of pressure).This deficient practice had the potential to place Resident 30 at risk for delay of care and treatment.Findings:During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included obstructive sleep apnea ([OSA] - a common, serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 30's History and Physical (H&P), dated 11/21/2025, the H&P indicated, Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/25/2025, the MDS indicated, Resident 30's cognitive (ability to think and reason) skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 30 required setup assistance (helper assists only prior to or following the activity) from with eating and oral hygiene. During a review of Resident 30's Order Summary Report (a document containing active orders), dated 2/11/2026, the Order Summary Report indicated, the physician placed a telephone order on 11/21/2025 for Resident 30 to start on BIPAP with Inspiratory Positive Airway Pressure ([IPAP] - higher pressure setting) of 18/5 centimeter ([cm] - unit of measurement) of H2O (water), Fraction of Inspired Oxygen ([FiO2] - the percentage or concentration) of 28 percent ([%]- unit of measurement) with full face mask size 18, at bedtime when sleeping and as needed. During a concurrent interview and record on 2/11/2026 at 10:10 a.m., with the Minimum Data Set Nurse (MDSN), Resident 30's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from January 1, 2026, to 2/11/2026, was reviewed. The MDSN stated Resident 30 was non-compliant and refused BIPAP treatment on 1/3/2026, 1/4/2026, 1/10/2026, 1/23/2026, 1/24/2026, 2/5/2026, and 2/8/2026. During a concurrent interview and record review on 2/11/2026 at 12:13 p.m., with the Director of Nursing (DON), Resident 30's care plans were reviewed. The DON stated there was no comprehensive care plan to address Resident 30's refusal to use BIPAP. The DON stated the purpose of care plan is for the healthcare team to identify and treat the problem and to provide intervention appropriately in order to provide standard of care to the resident. The DON stated without care plan, problem or issues of the resident will be left unattended. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure missing eyeglasses were replaced for one of four sampled residents (Resident 32). This deficient practice had the potential to violate the resident's right to have a grievance filed and ensure resident was comfortable at the facility. Findings: During a review of Resident 32's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated Resident 32's diagnoses' list included glaucoma (an eye condition that damages the optic nerve), cataracts (a cloudy or foggy area that develops in the lens of the eye, which is normally clear), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness, numbness, or reduced movement on one side of the body). During a review of Resident 32's care plan, dated 11/2024, the care plan indicated to ensure Resident 32 wore glasses when awake at all times. During a review of Resident 32's History and Physical (H&P) form, dated 9/5/2025, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/17/2025, the MDS indicated Resident 32's cognitive (thinking) skills were cognitively intact. The MDS also indicated Resident 32 was dependent on staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview, on 2/10/2026 at 9:24 a.m., with Resident 32, Resident 32 stated she had been wearing prescription eyeglasses since she was 8 years old. Resident 32 stated she had eyeglasses upon admission, and her eyeglasses were misplaced sometime during a room change. Resident 32 stated she was nearsighted (a common vision condition where close objects appear clearly, but distant objects look blurry). Resident 32 stated she informed the social worker and the Director of Nursing (DON) of her missing eyeglasses but had not received replacement eyeglasses. Resident 32 stated she had blurry vision due to not wearing her eyeglasses which resulted in her feeling frustrated. During a concurrent interview and record review, on 2/12/2026 at 8:14 a.m., with the Social Services Director (SSD), the SSD stated the protocol for misplaced eyeglasses was to call the facility's outside ophthalmology clinic immediately, see if the resident qualified for a replacement and have the eyeglasses replaced. The SSD stated if a resident did not qualify for a replacement, the facility would offer to pay for the resident. The SSD stated Resident 32 had a care plan indicating resident 32 should had been wearing eyeglasses at all times. The SSD stated she could not recall if Resident 32 told her about the missing eyeglasses and if Resident 32's glasses were missing, they should have been replaced. The SSD stated the risk of not replacing eyeglasses could result in eyesight deterioration, further decline in cataracts and glaucoma diagnoses. During an interview, on 2/12/2026 at 8:55 a.m., with the DON, the DON stated she was informed by Resident 32 of her missing eyeglasses. The DON stated Resident 32 had informed her a few days prior and the night before. The DON stated she did not inform Social Services nor any documentation regarding the missing eyeglasses. The DON stated the risk of not replacing lost glasses could result in worsening impaired vision. During a review of the (P&P), titled Theft and Loss, dated 11/14/2025, the P&P indicated Social Services staff or designee documents report(s) of lost and stolen resident property on the Theft and Loss Log. During a review of the (P&P), titled Social Services Coordinator Job Description, undated, the P&P indicated, Arrange ancillary services that have been determined necessary to maintain the residents' concrete needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1.Ensure a Stage 4 pressure ulcer wound care treatment was provided for 4 days for one of four sampled residents (Resident 6). This deficient practice had the potential to result in further skin breakdown.Findings: During a review of Resident 6's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 6's diagnoses included Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the hip, paraplegia (loss of movement and/or sensation, to some degree, of the legs), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs) and methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) carrier. During a review of Resident 6's history and physical (H&P) form, dated 11/13/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/18/2025, the MDS indicated Resident 6's cognitive (thinking) skills were cognitively intact. The MDS also indicated Resident 6 requires maximal assistance from staff with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 6's February 2026 Treatment Administration Record (TAR- a legal, daily log used by healthcare staff to track, sign off, and verify that a patient received their prescribed medication or treatment at the correct time and dose), the TAR indicated Resident 6's pressure ulcer wound care treatment of the left hip was not administered for 4 days: February 5th, 2026; February 8th, 2026; February 9th, 2026; and February 10th, 2026. During a concurrent interview and record review, on 2/11/2026 at 3:02 p.m., with the Treatment Nurse (TN 1), TN 1 stated Resident 6 had a left hip stage 4 pressure ulcer. TN 1 stated Resident 6 had an order to cleanse and pack his left hip wound daily. TN 1 stated she had been the treatment nurse for Resident 6 during the month of February. TN 1 stated on Resident 6's February 2026 TAR, there was no documentation of providing wound care treatment for 4 days. TN 1 stated the physician order for wound care treatment to the right hip should had been reordered for Resident 6. TN 1 stated she provided wound care treatment but maybe forgot to document. TN 1 stated the risk of not providing wound care treatment as order could result in further skin breakdown. During a review of the facility's policy and procedures, titled Skin Integrity Management, dated 7/30/2024, the P&P indicated, The facility will identify, evaluate, and intervene to prevent further pressure injury and/or heal pressure ulcers and any other skin integrity conditions. and Treatments administered will be documented in the resident medical Record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
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. Based on observation, interview, and record review, the facility failed to: 1. Ensure two of three residents' (Resident 2 and Resident 22) oxygen concentrator (machine that converts normal air to a more concentrated oxygen) was turned off when not in use. This failure had the potential to create an oxygen enriched environment, increased risk of fire hazards, equipment malfunction, and compromised resident safety.Findings:During a review of Resident 2's admission Record (Face Sheet). The Face Sheet indicated the facility admitted Resident 2 on 11/14/2019 with diagnoses including heart failure (a disorder which causes the heart to not pump the blood efficiently), history of cerebral infarction (stroke - loss of blood flow to a part of the brain due to blockage), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's History and Physical (H&P) dated 9/18/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 2 had severe cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 2 was dependent on staff for toileting, oral and personal hygiene, showering, upper and lower body dressing, and putting or taking off footwear. The MDS indicated Resident 2 needed oxygen therapy. During a review of Resident 22's admission Record (Face Sheet). The Face Sheet indicated the facility admitted Resident 22 on 12/26/2025 with diagnoses including respiratory failure with hypoxia (sudden inability to move oxygen from the lungs into the bloodstream), dementia (a progressive state of decline in mental abilities) and history of cerebral infarction (stroke - loss of blood flow to a part of the brain due to blockage). During a review of Resident 22's History and Physical (H&P) dated 12/16/2025, the H&P indicated Resident 22 had the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 22 had moderate cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 22 was dependent on staff with toileting, showering, lower body dressing and putting off and taking off footwear, needed maximum assistance (staff does more than half the effort to complete activity) with oral hygiene, upper body dressing and personal hygiene). The MDS indicated Resident 22 needed oxygen therapy. During an observation on 2/11/2026 at 9:07 a.m. in Resident 2's room, Resident 2 was not wearing her oxygen and the concentrator remained switched on. During an observation on 2/11/2026 at 9:56 a.m. in Resident 22's room, Resident 22 was not in the room and the concentrator remained switched on. During a concurrent observation and interview on 2/11/2026 at 10:01 a.m. with Licensed Vocational Nurse (LVN) 1 in the hallway near nurse's station one, Resident 2 was not receiving oxygen through nasal cannula (a flexible tube that delivers supplemental oxygen through the nose) and the concentrator remained switched on in Resident 2's room. LVN 1 stated the importance of turning off oxygen concentrators when not in use was to prevent equipment malfunction and accidents such as electrical fires. During an interview on 2/12/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated the importance of turning off oxygen concentrators when not in use was to prevent the machine from overheating causing the machine to break and to prevent accidents such as fires. During a review of the facility's policy and procedure (P&P) titled P-NP94 Oxygen Therapy revised 10/10/2025, the P&P did not indicate procedures regarding maintaining oxygen equipment when not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. ensure employee performance, competency validation, initial orientation validation, and orientation activities checklist were completed for 3 of 6 employees, RN1, LVN 2, and CNA 2. This failure had the potential to result in residents not receiving the required care based on the employee performance competency, orientation validation, and orientation activities provided for the proper care of the residents. Findings: During a review of the employee file of RN 1, the 2024 Annual Evaluation (yearly performance review) was not in the employee's file. During a review of the employee file for LVN 2, the Licensed Nurse Onboarding Activities Checklist (structured steps, training, and social interactions that integrate a new employee into an organization), dated 12/24/24, were missing validation of the following care requirements: Resident's Rights, admission Procedures, Discharge/Transfers, Psychotropics (medications to alter brain function, mood, perception, consciousness, and behavior) , Treatment Procedures, Enteral (methods of delivering nutrients, fluids, or medications directly into the stomach or intestines) , Change of Condition (a noticeable, significant, or unexpected difference in the physical, mental, or financial state of a person), Falls Management, Weights, Resident Care Plans (a written, personalized document that outlines a person's health conditions, needs, goals, and the specific daily actions or treatments required to support them), Interdisciplinary Referrals (a process where a healthcare provider directs a patient to a team of experts from different professional fields), Lab (a facility where tests are performed on blood, urine, or tissue samples, to obtain information about a patient's health), Advance Directive Documentation (a written statement of a person's wishes regarding medical treatment), Medicare Documentation (a federal health insurance program in the United States, primarily designed for people age [AGE] or older), Medical Records, Death of a Resident, Rounds (the daily, structured process of healthcare professionals visit patients to evaluate their condition, treatment plans, and update care), Committees (a small group of people appointed to investigate, discuss, and make decisions or recommendations), and External Resources (services for patient care obtained outside of an organization). During a review of the employee file for CNA 3, the Initial CNA Orientation Validation Checklist, undated, was not checked as completed, to indicate the procedure (step by step process for care of someone) for Basic Tuberculosis was met or not met. The Sit-to-Stand Lift Competency for CNA 3 did not have check marks to indicate CNA 3's competency for that task. During an interview and record review on 2/12/2026 at 2:27 p.m., with the Director of Staff Development (DSD), the DSD stated the sit to stand competency for CNA 3 was not completed. DSD stated staff need to know how to complete the task. If staff do not know, the resident could fall, the machine could slide if the brake was not placed, could hurt the resident if the device used is not adjusted properly or if it is not cleaned, it could spread germs to the residents. During an interview on 2/12/2026 at 2:48 p.m., with the Director of Nursing (DON), the DON stated that staff could fail to provide the right care and residents would not receive the proper care if the expected documents are not completed. Also, the residents could become sick from not receiving the care according to the facility's education process. During a review of the facility's policy and procedure titled, HR01 Staff Competency Validation Policy & Procedure, dated 3/28/2024, indicated, competency validation is completed to evaluate an individual's performance, evaluate group performance, meet standards set by regulatory agencies, address problematic issues, and enhance performance reviews. Competency validation is a determination based on an individual's satisfactory performance of each specific element of his/her job description, and of the specific requirements for the area in which he or she is employed. The purpose is to protect the health, safety, and well-being of residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure one of one resident's (Resident 49) mouth was rinsed after administration of prescribed inhaler Breo Ellipta [an inhaler used as a maintenance medication for asthma (a condition that causes the respiratory airways to swell up, shrink, and fill with mucus)].This failure had the potential to result in Resident 49 developing irritation of the mouth, discomfort, and an increased risk of infection of the mouth and throat due to medication remaining in the mouth after inhaler use.Findings:During a review of Resident 49's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 49 on 10/9/2025 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), mild intermittent asthma with acute exacerbation (a sudden or worsening of shortness of breath, wheezing, cough, chest tightness leading to a decline in lung function triggered by infection, allergens, or pollutants) and dysphagia (difficulty swallowing). During a review of Resident 49's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 49 did not have the capacity to make needs known or make decisions. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 49 had moderate cognitive (ability to think and understand). The MDS indicated Resident 49 was dependent (helper does all of the effort to complete the activity) on staff with toileting, showering, lower body dressing, and putting on or taking off footwear, needed partial assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort to complete the activity) with eating and oral hygiene, and needed maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort to complete the activity) with upper body dressing and personal hygiene. During a review of pharmacy's label for Breo Ellipta 100 mcg/25 mcg (micrograms - a unit of measurement) inhaler started on 1/28/2026 indicated, inhale 1 puff by mouth once daily, rinse mouth thoroughly after each use. During an observation 2/12/2026 at 9:05 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 49's room, LVN 3 did not instruct Resident 49 to rinse her mouth after administration of inhaler Breo Ellipta. During an interview on 2/12/2026 at 9:20 a.m. with LVN 3, LVN 3 stated she should have instructed Resident 49 to rinse her mouth after taking the inhaler. LVN 3 stated the importance of rinsing mouth after the inhaler was to prevent growth of fungus or bacteria in the mouth. LVN 3 stated if the resident did not rinse her mouth after taking the inhaler, there would be a potential that the resident could develop sores in the mouth that could get infected leading to a greater infection. During an interview on 2/12/2026 at 3:05 p.m. with the Director of Nursing (DON), the DON stated the importance of following pharmacy instructions to rinse mouth after administration of inhaler was to prevent fungal infection in the mouth. The DON stated if resident did not rinse her mouth after taking the inhaler, the resident would experience pain while eating and potentially lead to other infections of the body. During a review of the facility's policy and procedure (P&P) titled Oral Inhaler, dated 1/1/2012, the P&P did not indicate procedures regarding administration of corticosteroid [steroid - medication to reduce inflammation (swelling) in the body].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure medication error rate was less than five percent (%). Two errors out of 34 total opportunities contributed to an overall medication error rate of 5.88% for one of five residents (Resident 49) observed during medication administration (med pass).Resident 49's cholecalciferol (Vitamin D) 400 units [(IU - international units) a unit of measurement] tablet and fluticasone propionate suspension 50 mcg/act (micrograms per actuation- a unit of measurement) nasal spray were administered per physician's order. This failure had the potential to result in impaired bone health, increased fracture risk, respiratory complications, worsening allergy symptoms, nasal congestion and decreased comfort.Findings:During a review of Resident 49's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 49 on 10/9/2025 and was readmitted on [DATE] with diagnoses including fracture (broken bone) of left femur (the longest, strongest, and heaviest bone in the human body, located in the left thigh), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), mild intermittent asthma with acute exacerbation (a sudden or worsening of shortness of breath, wheezing, cough, chest tightness leading to a decline in lung function triggered by infection, allergens, or pollutants) allergic rhinitis (allergy - when the immune system mistakenly identifies harmless air particles such as pollen, pet dander, or dust mites as dangerous) and dysphagia (difficulty swallowing). During a review of Resident 49's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 49 did not have the capacity to make needs known or make decisions. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 49 had moderate cognitive (ability to think and understand). The MDS indicated Resident 49 was dependent (helper does all of the effort to complete the activity) on staff with toileting, showering, lower body dressing, and putting on or taking off footwear, needed partial assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort to complete the activity) with eating and oral hygiene, and needed maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort to complete the activity) from staff with upper body dressing and personal hygiene. During a review of Resident 49's Physician Orders dated 1/28/2026, the physician orders indicated cholecalciferol tablet 400 unit, give 1 tablet by mouth one time a day for supplement and fluticasone propionate suspension 50 mcg/mct micrograms per actuation- a unit of measurement) 1 spray each nostril one time a day for allergy. During an interview on 2/12/2026 at 9:20 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she did not administer the Vitamin D because the medication cart only had a 1000 unit dose available and she needed to check with central s upply if the facility had the 400 unit dose in stock. LVN 3 could not provide a reason why she did not administer the nasal spray. LVN 3 stated the importance of administering prescribed medications was to prevent allergy symptoms from getting worse and to supplement the resident's Vitamin D for her bones. LVN 3 stated if medications were not administered as prescribed, the resident's allergies can get worse and Vitamin D levels would be low. During an interview on 2/12/2026 at 3:05 p.m. with the Director of Nursing (DON), the DON stated the importance of administering prescribed medications was to ensure that any ongoing symptoms or disease were treated. The DON stated if medications were not administered as prescribed, the resident's symptoms could worsen placing the resident at risk for unresolved or uncontrolled medical issues. During a review of the facility's policy and procedure (P&P) titled NP76 Medication - Administration revised 6/26/2025, the P&P indicated All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure a resident who had a diagnosis of dementia (a progressive state of decline in mental abilities) and legally blind (severe vision loss) understands the legal documents (documents affecting the legal rights of any person) including Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all of certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not, the decision is final and can be enforced by a court, and can only be appealed on very narrow grounds) she signed during admission to the facility for one of three sampled residents (Resident 39). This deficient practice resulted for Resident 39 signing a facility contractual agreement without her full understanding.Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included dementia (a progressive state of decline in mental abilities), legal blindness (severe vision loss), and congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 39's History and Physical (H&P), dated 10/10/2025, the H&P indicated, Resident 39 did not have the capacity to understand and make decisions. During a review of Resident 39's Neuropsychiatric (branch of medicine that deals with the diagnosis, treatment, and prevention of mental disorders) Progress Note, dated 12/15/2025, the Neuropsychiatric Progress Note indicated, Resident 39 suffered from dementia and cognitive (ability to think and reason) communication deficit (lack or impairment in function) and any recommendations are subject to the approval of the interdisciplinary team (([IDT] - team members from different disciplines who come together to discuss resident care). During a review of Resident 39's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/15/2026, the MDS indicated, Resident 39's cognitive skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 39's vision was highly impaired. The MDS indicated, Resident 39 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper and lower body dressing, and personal hygiene. During a concurrent interview and record review on 2/12/2026 at 9:28 a.m., with the admission Coordinator (AC), Resident 39's Arbitration Agreement was reviewed. The AC stated Resident 39's Arbitration Agreement was signed electronically by resident on 12/30/2025. The AC stated he is responsible for completing the Arbitration Agreement with the resident upon admission. The AC stated Arbitration Agreement is a legal document, and both parties are bound to agreement. The AC stated Resident 39 is legally blind and has a diagnosis of dementia. The AC stated he should have not asked Resident 39 to sign the Arbitration Agreement. During an interview on 2/12/2026 at 10:11 a.m., with Resident 39, Resident 39 stated her vision was so blurry and she could hardly see. Resident 39 stated she could not recall signing the Arbitration Agreement. During an interview on 2/12/2026 at 10:17 a.m., with the Social Service Director (SSD), the SSD stated Resident 39 does not have an intact cognition. The SSD stated legal documents such as Arbitration Agreement should not be signed if resident did not have the capacity to understand. During an interview on 2/12/2026 at 1:24 p.m., with the Director of Nursing (DON), the DON stated Resident 39's Arbitration Agreement was not valid since Resident 39 is visually impaired and has diagnosis of dementia. The DON stated having Resident 39 sign the Arbitration Agreement is unacceptable because it takes away her rights to go to court. During a review of the facility's Policy and Procedure (P&P) titled, Arbitration Agreements, dated 5/26/2023, the P&P indicated, Residents should be given the opportunity to ask questions and clarify their understanding of the implications of signing the agreement. During a review of the facility's P&P titled, Informed Consent, dated 1/30/2026, the P&P indicated, If the resident lacks capacity to provide (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed consent and does not have a surrogate decision maker, the facility will convene a Surrogate interdisciplinary team (IDT).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to: 1. Ensure staff wore Personal Protective Equipment (PPE) when handling one of five resident's (Resident 21) gastrostomy tube (gtube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) who was on enhance barrier precautions (EBP - is an approach of targeted gown and glove use during high contact resident care activities).This failure had the potential to increase the risk of infection and cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) among residents.Findings:During a review of Resident 21's admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 21 on 7/2/2022 with diagnoses including hemiplegia (a medical condition characterized by paralysis or severe weakness on one entire side of the body) and hemiparesis (weakness on one entire side of the body) after a stroke (occurs when blood flow to a part of the brain is suddenly interrupted or a blood vessel in the brain bursts), dysphagia (difficulty swallowing), and gastrostomy status. During a review of Resident 21's History and Physical (H&P) dated 12/7/2025, the H&P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 21 had severe problems with thinking and memory. The MDS indicated Resident 21 was dependent on staff with eating, toileting, oral and personal hygiene, showering, lower body dressing and putting on or taking off footwear and needed maximum assistance (helper does more than half the effort to complete activity) with upper body dressing. During a review of Resident 21's Physician's Order dated 10/28/2024, the Physicians Order indicated Resident 21 was placed on Enhanced Barrier Precautions related to criteria being met every shift for Transmission-Based Prevention. During an observation on 2/12/2026 at 7:59 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 21's room, LVN 3 did not wear gloves when assessing Resident 21's gtube. During an interview on 2/12/2026 at 8:30 a.m. with LVN 3, LVN 3 stated she should have worn gloves prior to touching the gtube. LVN 3 stated the importance of wearing gloves while conducting high contact activities was to prevent the spread of bacteria throughout the facility. LVN 3 stated there would be a higher risk of spreading infection to other residents in the facility. During an interview on 2/12/2026 at 3:00 p.m. with the Director of Nursing (DON), the DON stated the importance of wearing PPE when taking care of residents on EBP was to prevent the spread of infection to other residents. The DON stated if PPE was not worn during high contact resident care activities there would be an increased risk for spreading the infection to other residents. During a review of the facility's policy and procedure (P&P) titled Personal Protective Equipment revised 1/1/2012, the P&P indicated .B. Gloves (sterile, non-sterile, heavy duty and/or puncture resistant) i. Facility staff wear gloves whenever there is touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin. During a review of the facility's P&P titled Enhanced Barrier Precautions revised 8/22/2019, the P&P indicated .II. Standard precautions will be used when there is any resident contact regardless of transmission risk of MDRO status. Standard precautions will include: . B. Gown, gloves, mask and face shield when a healthcare worker anticipates their hands, clothes or mucous membranes of the eyes, nose, mouth or skin on their face will be exposed to blood or other body fluids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to: 1. ensure that one of five residents, Resident 49, was provided COVID-19 and Influenza vaccines. This failure had the potential to place Resident 49 at risk of being infected with COVID-19 and Influenza viruses.Findings:During a review of Resident 49's admission Record, dated 1/28/2026, the admission Record indicated Resident 49 has Chronic Obstructive Pulmonary disease (a lung disease that makes it difficult to breathe) , mild intermittent asthma (a low-severity, lung condition characterized by infrequent coughing, wheezing, chest tightness) , and cognitive communication deficit (difficulty communicating due to underlying thinking disruptions rather than just language or speech problems). During a review of Resident 49's History & Physical, dated 1/29/2026, the History & Physical indicated Resident 49 does not have the capacity to understand and make decisions and Resident 49's potential for rehabilitation is fair to poor. During a review of Resident 49's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated to elevate head of bed at 30-45 degrees due to resident experiences shortness of breath when lying flat. During a review of Resident 49's Minimum Data Set, dated [DATE], the Minimum Data Set indicated Resident 49 has an active diagnosis of malnutrition (not eating the proper amount of calories and nutrients needed for the body to function properly), an active disease of the lungs (lungs not functioning properly, making it difficult to breathe and get enough oxygen), and shortness of breath when lying flat. During a review of Resident 49's Care Plan Summary, dated 2/3/2026, the Care Plan Summary indicated that Resident 49 is at risk for COVID-19 infection related to complex medical conditions. During a review of Resident 49's electronic immunization (the process of making a person immune or resistant to an infectious disease by administering a vaccine) record, not dated, the immunization record indicated that Resident 49 did not have any vaccines for COVID-19, and influenza. During an interview on 2/12/2026 at 9:15 a.m. with the Infection Preventionist (IPN) (a specialized healthcare professional who acts as a germ detective within hospitals and clinics), IPN stated, resident vaccines are supposed to be listed under immunizations in the electronic medical record. IPN stated they did not have an answer for why or when vaccine information is to be entered into the medical record. IPN stated staff would not be able to observe residents for adverse (any unexpected, unintended, and harmful reaction caused by a medication taken at normal doses) reactions if vaccines are not documented in the medical record. During an interview on 2/13/2026 at 8:03 a.m., with the Director of Nursing (DON), the DON stated residents should have immunizations and it is important for them to have a choice in receiving them. If residents do not receive immunizations, it could affect their overall health. During an interview on 2/13/2026 at 9:16 a.m., with the Administrator (ADM), the ADM stated that residents should have their immunizations. During a review of the facility's policy and procedure (P&P) titled, Management of COVID-19, dated 2022, the P&P indicated, Residents are encouraged to receive COVID-19 vaccination and boosters (an extra dose of a vaccine given after an initial, primary, vaccination), and the facility will maintain documentation of resident and staff vaccine status. During a review of the facility's policy and procedure (P&P) titled, Influenza Prevention and Control, dated 9/10/2020, the P&P indicated, the Resident's medical record will include documentation that indicates, at a minimum, the following: Whether the Resident received the influenza vaccine, could not receive the vaccine due to a medical contraindication, or refused the vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056143	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Healthcare & Wellness Centre	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)
F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure two of 19 sampled resident rooms (room [ROOM NUMBER] and 18) accommodated no more than four residents per room. This deficient practice had the potential to result in and/or create safety hazards, lack of privacy, and care issues for the residents.Findings:During facility tour on 2/12/2026 at 8:31 a.m., it was observed in room [ROOM NUMBER] that there was space for the beds, side tables, and resident care equipment's and there were no concerns with privacy and safety issues to the residents, and room [ROOM NUMBER] has five empty beds. During an interview on 2/12/2026 at 8:35 a.m., with the Administrator (ADM), the ADM confirmed room [ROOM NUMBER] bed (A, B, C, D, E) and room [ROOM NUMBER] beds (A, B, C, D, E) accommodated five residents. During a review of the facility's letter, titled Request for Waiver/Variations to Section 483.70, dated 2/10/2026, completed and submitted by the ADM, indicated the facility is submitting a renewal variation for accommodation of needs of more than four residents in one room. The facility waiver indicated the rooms with 5 residents are room [ROOM NUMBER] and 18 and each room has approximately 420 square feet ([sq. ft.] unit of measurement). The facility waiver indicated there were approximately 50% non-ambulatory and 50% ambulatory residents in each 5-bed room when fully occupied and both 5-bed rooms have a door with direct access to the corridor and to outside exposure at floor level.