

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Centinela Skilled Nursing & Wellness Centre West		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Flower Street 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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to: 1. Ensure a clear container which contained turkey sandwich meat was dated and labeled in the delivery freezer. This deficient practice had the potential to result in foodborne illness and contamination for 34 out of 54 residents. Findings: During a concurrent observation and interview, of the initial kitchen tour, on 11/18/2025 at 8:25 a.m., with the Dietary Supervisor (DS), a clear Tupperware container with a green lid was observed to not have a label of the food contained nor a date label in the Delivery refrigerator. The DS stated the turkey sandwich meat was used for snacks and sandwiches for the residents of the facility. The DS stated food items in the refrigerator were required to have a label, and an open and use by date. The DS stated the risk of not labeling the container of the turkey sandwich meat could result in residents consuming expired/spoiled food. During a review of the facility's policy and procedures (P&P), titled Food Storage, dated 7/25/2019, the P&P indicated all food items were to be correctly labeled and dated.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain dignity for one of 15 sampled residents (Resident 49) when Resident 49 was observed with eyeglasses that had the left lens taped into the frames. This deficient practice did not respect Resident 49's right to a dignified existence and placed Resident 49 at risk for injury related to broken eyeglasses. Findings: During a review of Resident 49's admission Record, the admission Record indicated Resident 49 was admitted on [DATE], and most recently readmitted on [DATE]. Resident 49's diagnoses included dementia (a progressive state of decline in mental abilities), history of falling, and cognitive communication deficit (trouble participating in conversations). During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool), dated 10/31/2025, the MDS indicated Resident 49 had adequate vision with eyeglasses. The MDS indicated Resident 49 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 49 required supervision or touch assistance from staff for walking. During a review of Resident 49's Ophthalmology (branch of medicine concerned with the diagnosis and treatment of disorders of the eye) Consult record, dated 5/27/2025, the record indicated Resident 49 had moderate cataracts (a clouding of the lens of the eye, which is typically clear) and blepharochalasis (a rare condition that causes painless swelling in your eyelids). The record also indicated Resident 49's ophthalmologist recommended an optometry referral for evaluation for glasses. During a review of Resident 49's Social Services Progress Note, dated 7/14/2025, the progress note indicated Resident 49 had an ophthalmology consult on 5/27/2025. The record did not indicate an optometry referral was made in accordance with the ophthalmologist's recommendation from 5/27/2025. The progress note did not indicate any information about new glasses. During an observation on 11/18/2025 at 10:22 a.m., at Resident 49's bedside, Resident 49 was observed sitting up in bed with eyeglasses on. The left lens of the eyeglasses was taped onto the frame. Resident 49 could not state if he had been seen by an optometrist. During an observation on 11/19/2025 at 2:45 p.m., at Resident 49's bedside, Resident 49 was observed lying in bed with eyeglasses on. The left lens of the eyeglasses was taped onto the frame. During an interview on 11/20/2025 at 10:14 a.m., with the Social Services Director (SSD), the SSD stated Resident 49 had been eligible for new eyeglasses since November 2024. The SSD stated an optometry referral was not made following the recommendation made by the ophthalmologist on 5/27/2025 for an evaluation for eyeglasses. During an observation on 11/20/2025 at 11:22 a.m., with Registered Nurse (RN) 2, at Resident 49's beside, Resident 49's eyeglasses were observed. RN 2 stated Resident 49's eyeglasses had tape on the left lens, holding the lens in place. RN 2 stated it was not dignified to wear eyeglasses in that condition. RN 2 stated a referral could be made to the optometrist to replace the glasses. RN 2 stated Resident 49 did not have alternative glasses. 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 all residents were to receive the services and support needed to maintain their highest practicable well-being. The P&P also indicated that each resident was to be cared for in a way that promoted dignity.		

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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 and interviews the facility failed to:1. Ensure call light device was placed within reach for one of 15 sampled residents (Resident 2).This deficient practice had the potential to result in a delay in or an inability for the residents to obtain necessary care and services. Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included muscle weakness, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified dorsalgia (a disorder characterized by back pain), and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a small open sore or wound found on the foot). During a review of Resident 2's History and Physical (H&P), dated 6/18/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. A review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, indicated Resident 2 was assessed to have comprehend (the action or capability of understanding something) most conversation. The MDS indicated Resident 2 required moderate assistance from staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) roll left and right, upper body dressing and dependent on staff for toileting, lying to sitting on bed, and personal hygiene. During a concurrent observation and interview on 11/18/2025 at 12:58 p.m. with Resident 2, in Resident 2's room, the call light was observed wrapped around the bed's siderail where the resident could not reach it. Resident 2 looked for the call light device, found the cord but could not untangle it from the bed's siderail and was unable to press the call light button. Resident 2 stated I can't reach the call light. Resident 2 stated If I can't reach the call light, I just call out when I need help, but it is not good if I can't tell the nurses when I need something right away or have an emergency. During a concurrent observation and interview on 11/18/2025 at 1:05 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 2's room, the call light was observed wrapped around the upper bed siderail and not within reach of the resident. CNA 1 stated the call light should have been placed next to the resident in case of an emergency. CNA 1 further stated that the call light was not within reach and Resident 2 could possibly not get the help needed. During an interview on 11/20/2025 at 12:40 p.m. with Registered Nurse (RN), the RN stated it is important that the call lights were within reach, if not within reach it could potentially delay the needs and care of the residents. During an interview on 11/20/2025 at 1:00 p.m. with the Director of Nursing (DON), the DON stated a resident's call light should always be within reach to notify staff if assistance was needed or in an emergency. The DON stated that if the call light was not within reach and the resident could not access it, there could be potential harm and the resident's needs would not be met. During a review of the facility's policy and procedure (P&P) titled, Communication - Call Light System, dated 8/24/2024, indicated, The call alert device will be placed within the resident's reach.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was accurately completed for one of 15 sampled residents (Resident 48). This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS, a federal agency that administers the Medicare and Medicaid programs) regarding Resident 1's health status. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 49 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 48's diagnoses included major depressive disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 48 did not have cognitive impairments (ability to think and reason). The MDS indicated Resident 48 required substantial to maximum assistance from staff for most mobility while out of bed. The MDS indicated Resident 48 routinely received antipsychotics (medications used to treat psychotic disorders). During a review of Resident 48's physician medication orders, dated 9/1/2025 to 11/20/2025, the orders indicated Resident 48 was not ordered antipsychotics. During an interview on 11/20/2025 at 8:23 a.m., with the MDS Coordinator (MDSC), the MDSC stated Resident 48 was not receiving antipsychotics during the timeframe specified in the MDS. The MDSC stated Resident 48 received an antidepressant (medication used to treat MDD). During an interview on 11/20/2025 at 10:07 a.m., with the MDSC, the MDSC stated Resident 48's MDS dated [DATE] indicated she routinely received an antipsychotic. The MDSC stated the manual (instruction tool for completing the MDS assessment) did not indicate that the antidepressant Resident 48 was receiving was the same as an antipsychotic. The MDSC stated Resident 48's MDS was not accurate. During a review of the facility's policy and procedure (P&P) titled RAI Process, revised 10/2016, the P&P indicated the purpose of the P&P was to provide resident-assessments that accurately depicted and identified resident-specific issues, while meeting state and federal guidelines. The P&P indicated the MDSC was to use the RAI Manual as a reference tool when completing the assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plans were developed for two of 15 sampled residents (Residents 32 and 49). This deficient practice placed Residents 32 and 49 at risk for not receiving the necessary interventions for their diagnoses and/or health problems. Findings: 1a. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was initially admitted to the facility on [DATE]. Resident 32's diagnoses included generalized muscle weakness, abnormalities of gait (manner of walking) and mobility, and dysphagia (difficulty swallowing). During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 32 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 32 used a walker and required set-up/clean-up assistance to eat. The MDS indicated Resident 32 had broken teeth. During a review of Resident 32's Fall Risk Evaluation, dated 10/22/2025, the evaluation indicated Resident 32 was identified as at risk for falls. During a review of Resident 32's medical records, the records indicated a care plan titled At risk for falls., was created on 11/18/2025. During an interview on 11/20/2025 at 8:49 a.m., with the Director of Nursing (DON), the DON stated staff were aware that Resident 32 was a fall risk on 10/22/2025. The DON stated a fall risk care plan should have been developed the same day. The DON stated Resident 32's fall risk care plan created on 11/18/2025 was not created timely. The DON stated the purpose of timely development of the fall risk care plan was for the safety of the resident. 1b. During a review of Resident 32's Social Services Assessment, dated 10/27/2025, the assessment indicated Resident 32 was to be referred for a dental consult due to having missing and broken teeth. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 had broken teeth. During a review of Resident 32's medical records, the medical records indicated Resident 32's care plan titled Oral/dental health problems related to obvious or likely cavity or broken natural teeth, was developed on 11/18/2025. During an interview on 11/20/2025 at 8:56 a.m., with the DON, the DON stated Resident 32's Social Services assessment dated [DATE], and MDS dated [DATE], indicated staff were aware of Resident 32's broken teeth. The DON stated a care plan should be developed for the condition of Resident 32's teeth because it could cause pain, or potentially affect her ability to eat, leading to weight loss. The DON stated the care plan should be developed as soon as the assessment was done to prevent complications. During an interview on 11/20/2025 at 9:00 a.m., with the DON, the DON stated Resident 32's care plan to prevent dental complications was created on 11/18/2025 and was not developed timely. The DON stated the care plan should have been created on 10/27/2025 or 10/29/2025, when it was identified by staff that Resident 32 had dental concerns. 2. During a review of Resident 49's admission Record, the admission Record indicated Resident 49 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 49's diagnoses included dementia (a progressive state of decline in mental abilities), history of falling, and cognitive communication deficit (trouble participating in conversations). During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 had adequate vision with glasses. The MDS indicated Resident 49 had moderate cognitive impairment, and required supervision or touch assist from staff for walking. During a review of Resident 49's Ophthalmology Consult, dated 5/27/2025, the record indicated Resident 49 had moderate cataracts (a clouding of the lens of the eye, which is typically clear), and blepharochalasis (a rare condition that causes painless swelling in your eyelids). During an interview on 11/20/2025 at 11:34 a.m., with Registered Nurse (RN) 2, RN 2 stated Resident 49 had vision problems which required resident-specific interventions. RN 2 stated these interventions should be documented in a care plan and stated Resident 49 did not have a care plan in place. During a review of the facility's policy and procedure (P&P), titled Person-Centered Care Planning, dated 2022, the P&P indicated staff were to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The P&P indicated the comprehensive care plan was to be developed within seven days from the completion of the comprehensive Minimum Data Set (MDS).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Review, update, and/or revise the care plan to address supervision while smoking for two of five sampled residents (Residents 10 and 54). This deficient practice had the potential to result in injury to Residents 10 and 54 due to conflicting documentation and inadequate supervision while smoking. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE]. Resident 10's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) to right and left side, paraplegia (loss of movement and/or sensation, to some degree, of the legs), and muscle weakness (generalized). During a review of Resident 10's History and Physical (H&P), dated 9/19/2025, the H&P indicated Resident 10 had the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated 10/30/2025, the MDS indicated Resident 10 had clear comprehension (ability to learn, reason, remember, understand, and make decisions). The MDS indicated Resident 10 required maximal assistance with bed mobility, toilet use, personal hygiene, upper and lower body dressing, and was totally dependent with tub/shower transfer. During a review of Resident 10's Smoking and Safety Assessment, dated 10/29/2025, the smoking and safety assessment indicated, Resident 10 had insufficient fine motor skills needed to securely hold tobacco. Staff will supervise resident while smoking. During a review of Resident 10's Multidisciplinary Care Conference (IDT), dated 10/09/2025, the IDT indicated Resident 10 requires assistance from staff with getting around due to limited function from her hands. Resident 10 also required assistance from staff when going outside to smoke. Staff will continue to assist Resident 10 with getting around and with smoking. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE]. Resident 54's diagnoses included Type 2 Diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), absence of right leg below knee, muscle weakness (generalized) and lack of coordination. During a review of Resident 54's H&P, dated 8/15/2025, the H&P indicated Resident 54 had the capacity to understand and make decisions. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 had clear comprehension. The MDS indicated Resident 54 required supervision with bed mobility, lower body dressing and was needed moderate assistance with showering and toileting. During a review of Resident 54's Care Plan for [NAME] Use, dated initiated 8/15/2025 and revision on 10/01/2025, The care plan indicated the resident both required supervision and did not require supervision. During a concurrent interview and record review on 11/21/2025 at 10:25 a.m. with the MDS Coordinator (MDSC), Resident 10's Care Plan for Tobacco Use, last revision dated 9/9/2025 was reviewed. The care plan indicated Resident 10 both requires and did not require supervision while smoking. The MDSC stated no, the care plan should not have both require supervision and does not require supervision, that was confusing. The MDSC stated the care plan should be patient centered and needs to indicate which supervision is required, this should have been addressed during the revision of the care plan. The MDSC stated that care plans are important, they need to be reviewed, updated, and/or revised to make sure any issues with the residents are properly addressed. During an interview on 11/21/2025 at 11:05 a.m. with Director of Nursing (DON), the DON stated care plans were completed on admission, revised quarterly and as needed. The DON stated care plans were to be resident-centered, very specific and should not contain conflicting information. The DON stated the care plan was used as a guide for patient care and if interventions were conflicting, it would be confusing to the nursing staff. The DON stated that these types of issues should be addressed as (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soon as possible or during the revision process. The DON stated a revision involved reviewing the care plan and making necessary changes. The DON stated it was important that care plans were correct and updated in a timely manner. During a review of the facility's policy and procedure (P&P) titled, Smoking Residents, dated 8/18/2023, the P&P indicated, The IDT (Interdisciplinary Team) will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Failed to ensure blood glucose monitoring and insulin orders were clarified and continued after being readmitted from the hospital for one of five sampled residents (Resident 8). This deficient practice had the potential to result in Resident 8 having a hypoglycemic (low blood glucose) or hyperglycemic (high blood glucose) episode. Findings: During a review of Resident 8's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 8 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), hypotension (low blood pressure) and dementia. During a review of Resident 8's history and physical (H&P) form, dated 11/4/2025, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/8/2025, the MDS indicated Resident 8's cognitive skills were severely impaired. The MDS indicated Resident 8 was dependent on staff members 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 8's October 2025 Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicate Resident 8 had a physician's order for NovoLog Flex Pen Solution (a medication used to help manage blood sugar levels in people with type 1 or type 2 diabetes) per sliding scale. During a review of Resident 8's October 2025 MAR, the October 2025 MAR showed Resident 8 received insulin for 14 days out of the whole month as needed per sliding scale. During a review of Resident 8's blood glucose levels, dated 10/1/2025, Resident 8 received insulin on 10/23/2025 before being transferred to a general acute care hospital (GACH). During a review of Resident 8's GACH records, Resident 8 received insulin in the GACH on 10/25/2025. During a review of Resident 8's progress notes, dated 11/1/2025, Resident 8 was readmitted to the facility on [DATE]. During a review of Resident 8's physician orders, dated 11/1/2025, the physician orders did not indicate to continue Resident 8's insulin. During a concurrent interview and record review, dated 11/20/2025 at 9:30 a.m., with the Director of Nursing (DON), the DON stated she had readmitted Resident 8 back to the facility. The DON stated the protocol for readmitting diabetic residents was to call the resident's doctor to verify the previous insulin order and carry out any new orders. The DON stated Resident 8 had a physician's order for insulin in October 2025. The DON stated Resident 8's blood glucose monitoring and insulin orders should have been clarified with the doctor upon readmission to the facility. The DON stated the risk of not clarifying or continuing insulin for a diabetic resident could result in a hypo/hyperglycemic episode. During an observation, dated 11/20/2025 at 10:03 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 checked Resident 8's blood glucose level which was 141. During a review of the facility's policy and procedures (P&P), titled Resident Rights- Quality of Life, revised 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 services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being.		

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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 interview and record review, the facility failed to ensure an optometry (the practice or profession of examining the eyes for visual defects and prescribing corrective lenses) referral was made for one of one sampled residents (Resident 49). This deficient practice placed Resident 49 at risk of not receiving the necessary care and interventions needed to maintain his vision and quality of life. Findings: During a review of Resident 49's admission Record, the admission Record indicated Resident 49 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 49's diagnoses included dementia (a progressive state of decline in mental abilities), history of falling, and cognitive communication deficit (trouble participating in conversations). During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool) dated 10/31/2025, the MDS indicated Resident 49 had adequate vision with glasses. The MDS indicated Resident 49 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 49 required supervision or touch assist from staff for walking. During a review of Resident 49's Ophthalmology (the branch of medicine concerned with the diagnosis and treatment of disorders of the eye) Consult record, dated 5/27/2025, the record indicated Resident 49 had moderate cataracts (a clouding of the lens of the eye, which is typically clear) and blepharochalasis (a rare condition that causes painless swelling in your eyelids). The record also indicated Resident 49's ophthalmologist recommended an optometry referral for an evaluation for glasses. During a review of Resident 49's Social Services Progress Note, dated 7/14/2025, the progress note indicated Resident 49's most recent ophthalmology consult was 5/27/2025. The progress note did not indicate an optometry referral was made in accordance with the ophthalmologist's recommendation from 5/27/2025. During an interview on 11/20/2025 at 10:14 a.m., with the Social Services Director (SSD), the SSD stated she reviewed the ophthalmology consult notes after the ophthalmologist's visit. The SSD stated that if an optometry referral was recommended, she would make the referral. The SSD stated the optometrist visited the facility every two to three months and she would notify them if there was someone with an optometry referral. The SSD stated an optometry referral was not made for Resident 49 following the recommendation made by the ophthalmologist on 5/27/2025. The SSD stated it was important to ensure optometry referrals were made timely to treat any vision conditions. The SSD further stated that difficulty with vision could affect quality of life and pose safety risk for the resident.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Failed to ensure oxygen was administered as ordered for one of five sampled residents (Resident 24).This deficient practice had the potential to result in oxygen toxicity for Resident 24.Findings:During a review of Resident 24's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 24 was admitted [DATE] on with diagnoses which included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness) and pulmonary hypertension (high blood pressure that affects the arteries in the lungs and the right side of the heart).During a review of Resident 24's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/18/2025, the MDS indicated Resident 24's cognitive skills were cognitively intact. The MDS indicated Resident 24 required partial to moderate assistance from staff members 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 24's physician orders, dated 9/26/2025, the physician orders indicated, May use Oxygen @ 2-3L/min Via nasal cannula to keep O2 Sat above 92 % as needed for SOB.During a review of Resident 24's history and physical (H&P) form, dated 11/2/2025, the H&P indicated Resident 24 had the capacity to understand and make decisions.During an observation, on 11/18/2025 at 11:12 a.m., Resident 24 was observed receiving oxygen via nasal cannula at 4 liters per min.During a concurrent observation and interview, on 11/20/2025 at 10:15 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 observed Resident 24 receiving oxygen via nasal cannula in bed. LVN 1 stated Resident 24's oxygen was running at 4 liters per minute. LVN 1 stated Resident 24's physician order indicated to administer 2-3 liter per minute. LVN 1 stated Resident 24's oxygen should not had been running at 4 liters per minute. LVN 1 stated the risk of administering oxygen at a higher dose than the physician's order could result in oxygen toxicity.During a review of the facility's policy and procedures (P&P), titled Oxygen Therapy, dated 10/10/2025, the P&P indicated, Administer oxygen and obtain oxygen saturation levels as ordered by the provider.		

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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. Provide pharmaceutical services that met the needs one of five sampled residents (Resident 24). Resident 24's lidocaine patch was not removed at the scheduled time as ordered by the physician. This deficient practice had the potential for avoidable physical harm related to lidocaine patch not being removed on time or experiencing potential adverse drug reactions from medications being administered differently from how they were ordered. Findings: During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE]. Resident 24's diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), hypertensive heart disease with heart failure (long term high blood pressure caused the heart to weaken, making it unable to pump blood effectively), chronic pain syndrome (pain that lasts longer than three months). During a review of Resident 24's History and Physical (H&P), dated 11/02/2025, the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS) a comprehensive assessment and care-screening tool), dated 9/18/2025, the MDS indicated Resident 24 had clear comprehension (ability to learn, reason, understand, and make decisions). The MDS indicated Resident 24 required supervision with bed mobility, toilet use, personal hygiene, upper and lower body dressing. During an observation on 11/20/2025 at 9:23 a.m. in Resident 24's room during medication pass, a lidocaine patch dated 11/19/2025 was observed still placed on Resident 24's left leg. Observed the LVN1 quickly removing the lidocaine patch, cleaned and assessed area before placing a new lidocaine patch to left leg. During a concurrent interview and record review on 11/20/2025 at 11:15 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 24's Medication Administration Record (MAR), dated November 2025 was reviewed. The Mar indicated Lidocaine patch was to be removed at 8:59 p.m. each day as ordered. LVN 1 stated the lidocaine patch from the previous day was still on the resident which I removed immediately. LVN 1 stated no, it should not have been left on, it is important to follow physician orders. LVN 1 stated leaving the patch on longer than ordered could potentially harm the resident due to medication levels becoming too high. During an interview on 11/20/2025 at 11:30 a.m. with Director on Nursing (DON), the DON stated medication orders should be followed as scheduled. The DON stated that if a lidocaine patch was left on a resident after the scheduled removal time the patch would still be distributing medication to the resident's system. The DON stated this could potentially cause adverse side effects, skin irritation, and harm to the resident. During a review of the facility's policy and procedure (P&P) titled, Medication- Administration, dated 8/19/2025, 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. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.		

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Form Approved OMB
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews the facility failed to: 1. Ensure an unopened prefilled pen of Lantus (a long-lasting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication]) was stored inside the refrigerator per manufacturer's guidelines instead of storing inside Medication Cart Westback. This deficient practice had the potential to result in the deterioration and loss of effectiveness for insulin Lantus' improper storage and potential for ineffective management of the residents' diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Findings: During a concurrent observation and interview on 11/20/2025 at 12:35 p.m. with Registered Nurse (RN) 1 at medication cart westback, an unopened prefilled pen of Lantus was observed in the medication cart. RN 1 acknowledged that the insulin was stored in the cart unopened. RN 1 stated that all unopened insulin prefilled pens and vials should be stored in the refrigerator until they are opened. RN 1 stated once an insulin vial was opened it could remain in the cart for 28 days. RN 1 stated if an unopened insulin was stored in the medication cart and not refrigerated it could affect the resident by causing the insulin to be less effective, leading to poor blood sugar control and potentially could result in the resident requiring hospitalization. During an interview on 11/21/2025 at 11:05 a.m. with the Director of Nursing (DON), the DON stated all unopened insulin was required to be stored in the refrigerator until used. The DON stated the insulin was stored in the refrigerator to maintain the accuracy and potency of the medication. The DON stated storing the insulin outside of the refrigerator could affect its effectiveness, and if the insulin was ineffective the residents' blood sugar would continue to rise and cause potential harm. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, August 2019, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. For those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. Medications requiring refrigeration are kept in a refrigerator with a thermometer to allow temperature monitoring.		

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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 ensure the correct information was provided to one of three sampled residents (Resident 7) prior to asking him to enter into a binding arbitration agreement (the resolution of a dispute where both parties waive their right to a trial). This deficient practice resulted in Resident 7 unknowingly forfeiting his right to resolve any disputes with the facility in court, alongside a judge and/or jury. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE]. Resident 7's diagnoses included surgical aftercare for amputation of both legs below the knee and polyneuropathy (nerve damage). During a review of Resident 7's History and Physical (H&P), dated 9/25/2025, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's record titled Arbitration Agreement, dated 9/25/2025, the record indicated Resident 7's daughter signed the document, entering Resident 7 into a binding arbitration agreement. During an interview on 11/21/2025 at 10:01 a.m., with Resident 7, Resident 7 stated he was responsible for signing all the paperwork presented to him upon admission and stated he would not ask his daughter to sign anything. Resident 7 stated binding arbitrations were not explained to him, and stated he would not have agreed to one if it were explained to him. During an interview on 11/21/2025 at 10:36 a.m., with the Admissions Director (AD), the AD stated Resident 7's daughter's signature on Resident 7's Arbitration Agreement was an error, and stated he recalled Resident 7 signing the document himself. During an interview on 11/21/2025 at 10:37 a.m., the AD stated he was responsible for explaining binding arbitrations to new facility residents. The AD stated he informed residents that a binding arbitration agreement outlined the rules and regulations of the facility, like a code of conduct. The AD stated he had not received training by the facility about what a binding arbitration agreement was. During an interview on 11/21/2025 at 1:09 p.m., with the Administrator (ADM), the ADM stated a binding arbitration was an agreement to give away the right to a court trial if there was a dispute between the resident and the facility. The ADM stated that once the agreement was signed, it was a legally binding contract. The ADM stated that prior to being asked to sign the document, the facility should fully inform the resident of what they are being asked to sign, and stated it was the resident's right to know what they were signing. During a review of the facility's policy and procedure (P&P) titled Arbitration Agreements, dated 5/26/2023, the P&P indicated that when admission staff were presenting the Arbitration Agreement to residents, the admissions staff must explain what arbitration is in a language and manner that resident and or responsible party understands.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control for all facility residents when: 1. Resident 48 was not tested for Covid-19 (an infectious disease caused by the SARS-CoV-2 virus) after first exhibiting symptoms on 11/12/2025. 2. The facility failed to ensure there was warm running water in the handwashing sink located in the soiled laundry sorting area. These deficient practices created the potential for the transmission and spread of infection to all facility residents. Findings: 1. During a review of Resident 48's admission Record, the admission Record indicated Resident 49 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 48's admitting diagnoses included sepsis (a life-threatening blood infection). During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool), dated 9/14/2025, the MDS indicated Resident 48 did not have cognitive impairments (ability to think and reason). The MDS indicated Resident 48 required substantial to maximum assistance from staff for most mobility while out of bed. During a review of Resident 48's physician order, dated 7/28/2022, the order indicated Resident 48 was to be tested for Covid-19 weekly and as needed. During a review of Resident 48's test results, dated 11/2025, the records indicated Resident 48 was last tested for Covid-19 on 11/10/2025 and no further Covid-19 testing was conducted. During a review of Resident 48's Change of Condition (COC) assessment, dated 11/12/2025, the COC assessment indicated Resident 48 had a severe cough with yellow/greenish phlegm, chest congestion, difficulty breathing, and a runny nose/nasal congestion. During a review of Resident 48's COC assessment, dated 11/18/2025 at 11:00 a.m., the COC assessment indicated Resident 48 had increased cough with white, cloudy sputum production (a mixture of saliva and mucus), chest congestion, and mild chest tightness. The assessment did not indicate Resident 48 was tested for Covid-19. During a concurrent observation and interview, on 11/18/2025 at 1:34 p.m., at Resident 48's bedside, Resident 48 was observed sitting up in bed with a strong cough. Resident 48 stated she had been coughing for a week and was spitting up large amounts of white, creamy sputum. Resident 48 stated she was also very fatigued and was not getting a lot of sleep due to the frequent coughing. During an interview on 11/20/2025 at 9:02 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated that any resident with a cough and/or fever were to be tested for Covid-19. The IPN stated that it was important to test right away to prevent the spread of infection to staff and other facility residents. During an interview on 11/20/2025 at 9:21 a.m., with the IPN, the IPN stated Resident 48 had not been tested for Covid-19 since her coughing started. During a review of the facility's policy and procedure (P&P) titled [Facility] Respiratory Virus Prevention and Control Plan, reviewed 8/27/2025, the P&P indicated that any residents with signs and/or symptoms of respiratory illness were to be tested immediately for Covid-19. 2. During an interview on 11/21/2025 at 1:07 p.m., in the sorting area for soiled linen in the laundry room, with the Housekeeping Supervisor (HS), the HS stated this was considered a dirty area where soiled linens were brought to be separated and sorted for washing. The HS stated staff washed their hands in the handwashing sink for infection prevention. During an observation on 11/21/2025 at 1:09 p.m., in the sorting area for soiled linen in the laundry room, the handwashing sink was observed. The handwashing sink had a hot-water pedal and a cold-water pedal. The hot-water pedal did not dispense any water when pressed. The handwashing sink did not dispense any hot or warm water. Signage above the handwashing sink instructed staff to wash their hands with warm running water. During an interview on 11/21/2025 at 1:12 p.m., with the Maintenance Supervisor (MS), the MS stated the hot water in the handwashing sink was turned off six months ago. The MS could not state who instructed him to turn off the hot water, and stated it was turned off because the handwashing sink had an attached eyewash station (a unit for washing off chemicals or substances that might have splashed into an individual's eyes). During an interview on 11/20/2025 at 1:53 p.m., with the IPN, the IPN stated she had never received guidance that hot water was to be disconnected at an eye-wash (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	station. The IPN stated the water should be warm enough for effective handwashing, and cool enough that it would not burn someone's eyes if they needed the eyewash. The IPN stated hand hygiene (handwashing) was to be done with warm water for effective handwashing and infection prevention. During a review of the facility's P&P titled Hand Hygiene, revised 9/2020, the P&P indicated the Facility considered hand hygiene as the primary means to prevent the spread of infections.		