| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555719 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Imperial Crest Health Care Center | 11834 Inglewood Avenue<br>Hawthorne, CA 90250 |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food safety and sanitary food storage and preparation practices were maintained in the kitchen, by failing to:Ensure one container of Italian dressing was labeled with an opened date and/or use-by date. Maintain cold food items at safe temperatures when three-bean salads measured 57 to 66 degrees Fahrenheit ( F, a scale of temperature) during meal service.Ensure bowls of vanilla mousse were properly immersed in an iced-holding bin or storage, to maintain a safe, cold holding temperatures of 41 F and below during tray line pre-service handling. These deficient practices had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 54 medically compromised residents who received food from the kitchen.Findings:During a concurrent observation and interview on 5/19/2026 at 8:55 a.m., with the Registered Dietitian (RD), one container of Italian dressing was observed stored in the kitchen refrigerator without an opened and/or use-by date. The RD stated that all food items should be labeled with the date opened and use-by date to identify when the item was opened and to determine when it was no longer safe for consumption. The RD stated that without an opened date and use-by date, kitchen staff would be unable to determine how long the item had been stored in the refrigerator, creating the potential for the item to be used beyond a safe time frame. During a record review of the facility's Spring Menu, dated 5/19/2026, the menu indicated on 5/19/2026, three bean salad and vanilla mousse were scheduled to be served for lunch on 5/19/2026.During a review of the facility's Recipe of Broccoli Salad, dated 2025, the recipe indicated the three-bean salad was to be prepared and refrigerated at 41 degrees Fahrenheit ( F, a scale of temperature) or below until meal service. The recipe indicated the kitchen staff were to serve the three-bean salad on the tray line at the recommended temperature of 41 F or below. During a concurrent observation and interview on 5/19/2026 at 12:00 p.m., with the RD, observed one pre-plated cup of three-bean salad measured at 50 F. In addition, one cup of three-bean salad held in an ice-holding bin measured at 66 F. The RD stated the three-bean salads temperature exceeded 41 F, which created the potential for bacterial growth and foodborne illness if the salads were to be consumed by the residents. During a review of the facility's Recipe of Vanilla Mousse, dated 2026, the recipe indicated the vanilla mousse was to be prepared and kept chilled in the refrigerator at 41 F or below. The recipe indicated the kitchen staff were to serve the vanilla mousse on the tray line at the recommended temperature of 41 F or below. During a concurrent observation and interview on 5/19/2026 at 12:20 p.m., with RD, observed bowls of vanilla mousse held in an ice-holding bin. The ice did not fully surround the bowls to ensure temperature control. The temperature of three randomly selected bowels of vanilla mousse in the ice-holding bin measured 50 F. The RD stated the vanilla mousse was not maintained under 41 F. RD stated the vanilla mousse should be maintained at 41 F or below prior to serving to residents to prevent bacterial growth and the risk for foodborne illness if consumed by residents. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19. Time/Temperature Control for safety food shall be<br>(continued on next page) |

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

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | maintained: (2) At 5 C (41 F) or less.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised 11/2022, the P&P indicated refrigerator foods must be labeled, dated, and monitored to ensure use by their use-by date.During a review of the facility's P&P titled Menu Service, undated, the P&P indicated salads and desserts must be served at 40 F or below. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eleven residents (Resident 49) observed during medication administration (MedPass) was administered Humalog insulin (a fast-acting prescription medication used to lower blood sugar [BS] in people with diabetes- a chronic condition in which the body either does not produce enough insulin [a hormone that removes excess sugar from the blood] or cannot use insulin effectively, resulting in high levels of blood sugar) within 15 minutes of a meal and injection site rotated after each injection, as ordered and in accordance with manufacturer's specifications. This deficient practice increased the risk of Resident 49 experiencing harmful effects from uncontrolled blood sugar, which could lead to dizziness, confusion, unconsciousness, coma, and hospitalization. The facility's failure to alternate or rotate Resident 49's insulin injection site created the potential of scar tissue build up which may decrease medication absorption and therapeutic effectiveness of the medication's ability to prevent adverse reactions (harmful or unwanted effects) from both the insulin medication and the diabetes disorder. Findings:During a review of Resident 49's admission Record ( a document containing diagnostic and demographic information), the admission Record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses that included Type II Diabetes Mellitus (DM2), long term use of insulin, hypertension (high blood pressure), and long term use of oral hypoglycemic (lowering blood sugar level) drugs. During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool), dated 4/20/2026, the MDS indicated Resident 49's cognitive skills for daily decisions making was intact. During a review of Resident 49's care plan focus indicated, the resident has Diabetes and is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to Diabetes Mellitus.care plan dated 4/29/2025, Resident 49's care plan goals included the resident will have no unrecognized s/s (signs and symptoms) of hypoglycemia and hyperglycemia as evidence by: no tremors, no diaphoresis (excessive sweating), no change in level of consciousness daily. Resident 49's care plan Interventions included; diet as ordered; monitor food intake and record; offer HS (bedtime) snacks as ordered; administer medications as ordered; monitor for s/s of hypoglycemia.monitor s/s of hyperglycemia, polydipsia (excessive thirst), polyuria (excessive urination), increased blood glucose (blood sugar)., deep and rapid breathing., weakness, abdominal pain, general aches. During a review of Resident 49's Order Summary Report, signed by physician on 5/7/2026, included and not limited to the following orders:Humalog (Insulin Lispro) KwikPen (a prefilled insulin injection pen) Injection 100 units per milliliter (ml, unit of measurement), instructions indicated, inject as per sliding scale: if BS0 (zero) -149 = 0 unit;150 -199 = 3 units;200 - 249 = 4 units;250 - 299 = 5 units;300 - 349 = 6 units;350 - 399 = 7 unitssubcutaneously (SQ, injection just under the skin) before meals and at bedtime for DM2. Call MD if BS above 400, or below 70. Give no more than 15 minutes before the meals or give at the beginning of the meal (up to 15 minutes after the start of the meal) and to hold the dose if a meal is skipped. Rotate Site, order date 1/31/2023. During a review of Resident 49's Medication Administration Records (MAR, official documents recording the administration of medications to residents, including drug name, dosage, time, and route) for the Months of April 2026 and May 2026, the MAR for Resident 49 indicated the resident was ordered Humalog to be administered by SQ injection per sliding scale four times a day before meals and at bedtime, scheduled administration times were 6:30 AM, 11:30 AM, 4:30 PM, and 9 PM daily. Licensed nurses documented administration of Humalog scheduled for 11:30 AM administration was administered between 4/26/2026 through 5/20/2026 as follows. On: 4/10/2026- injected 4 units at 11:03 AM04/15/2026 - injected 4 units at 11:43 AM04/17/2026 - injected 4 units at 11:11 AM4/26/2026 - injected 3 units at 10:50 AM5/16/2026 - injected 3 units at 10:47 AM5/20/2026 - injected 4 units at 10:41 AM During a concurrent observation and interview on 5/20/2026, at 10:34 (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | AM, with a Licensed Vocational Nurse (LVN) 4, on Nursing Station 2 at Medication Cart (MedCart) 2, LVN 4 checked Resident 49's BS level and stated the resident's BS was 200 and required four (4) units of Humalog per sliding scale dosing. LVN 4 dialed up 4 units of Humalog. LVN 4 entered the Resident 49's room and stated the insulin was injected into the right upper quadrant (RUQ) of the resident's stomach. There was no meal or snack observed available or offered to Resident 49. During an interview on 5/20/2026 at 2:06 PM, with LVN 4, LVN 4 stated Resident 49 receives lunch at 12:15 PM. LVN 4 stated Resident 49 normally receives Humalog insulin around 10:30 AM and LVN 4 stated the insulin was administered today, 5/20/2026 at 10:41 AM. During a concurrent interview and record review on 5/20/2026 at 2:09 PM with LVN 4, Resident 49's Order Summary Report was reviewed for Humalog. LVN 4 stated that Resident 49's Humalog order indicated to give Humalog per sliding scale no more than 15 minutes before the meal or no longer than 15 minutes after the start of the meal and hold if the meal is skipped. LVN 4 stated that she saw the order but did not remember the insulin must be given with a meal. LVN 4 stated Resident 49's Humalog must be given with a meal to help control the BS level during that meal and if Humalog is given on an empty stomach the resident's BS could drop too low. During a concurrent interview and record review on 5/20/2026 at 2:15 PM, with LVN 4, Resident 49's MAR, Location of Administration Report, was reviewed for 5/20/2026. Resident 49's MAR, Location of Administration Report, indicated the resident's Humalog was injected on 5/20/2026 at 6:36 AM RUQ and at 10:41 AM RUQ. LVN 4 stated that she should not have injected the Humalog insulin into the same injection site (RUQ) as the previous dose and should have rotated the insulin injection site. During a concurrent interview and review of mealtimes and snack/nourishment schedules on 5/21/2026 at 3:14 PM, with the Dietary Supervisor (DS), DS stated Resident 49 was not on the list to receive morning, afternoon or bedtime snacks/ nourishment. DS stated mealtimes are posted and the scheduled mealtimes are:Breakfast was scheduled from 7:15 AM to 8:00 AMLunch was scheduled from 12:15 PM to 1:00 PMDinner was scheduled from 5:15 PM to 6:00 PM During a concurrent interview and record review on 5/21/2026 at 3:32 PM, with the Director of Nursing (DON), Resident 49's Order Summary and MAR for the Month of May 2026 were reviewed. DON stated according to Resident 49's physician orders the insulin injection sites must be rotated for each administration to avoid infection, redness, or swelling at the injection site. DON stated that Resident 49's Humalog insulin is fast acting and must be given with meals, within 10 to 15 minutes of the meals. The DON stated Resident 49's Humalog insulin should not be given an hour before a meal, must be given with meals for resident's safety. DON stated that Resident 49's Humalog was scheduled to administer at 11:30 AM, the resident's lunch was scheduled for 12:15 PM daily and Resident 49's physician order indicated to administer Humalog to the resident 15 minutes before the meal and hold if resident do not eat. The DON acknowledged that licensed nurses documented Resident 49's administration of Humalog scheduled for 11:30 AM as administered as follows. On:5/16/2026 - injected 3 units at 10:47 AM5/20/2026 - injected 4 units at 10:41 AM. The DON stated that Resident 49's evening Humalog insulin injection scheduled for 4:30 PM administration time should have been given with dinner, which was scheduled at 5:15 PM daily. The DON acknowledged that licensed nurses documented Resident 49's administration of Humalog scheduled for 4:30 PM as administered as follows. On:5/12/2026 - injected 3 units at 7:41 PM5/15/2026 - injected 3 units at 6:46 PM5/16/2026 - injected 3 units at 6:40 PM5/20/2026 - injected 3 units at 6:42 PM. DON stated Resident 49's Humalog should have been administered with dinner as ordered. During a concurrent interview and record review on 5/21/2026 at 3:59 PM, with the DON, the DON stated after reviewing Resident 49's MAR Location of Administration for the Month of May 2026, that the resident was documented to have been administered Humalog insulin at the same injection site on 5/16/2026 for three dose into the left lower quadrant (LLQ) of the stomach for the 11:30 AM, 4:30 PM, and 9:00 PM scheduled administration times and for two doses at the same injection site on 5/20/2026 injection into the RUQ of the stomach for the 6:30 AM and 11:30 AM scheduled administration times. DON stated licensed nurses can check the manufacturer labeling to ensure they understand how to<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | administer medication for the safety of the resident and to know how the medication works and they could call the facility's pharmacist as needed for drug information. During a telephone interview on 5/21/2026 at 4:21 PM, with the facility's Consultant Pharmacist (Pharm) 1, in the presence of the DON, Pharm 1 stated, Humalog is a fast-acting insulin and should be taken as a resident starts to eat, the onset of action engages rapidly to help control the BS spikes during a meal. Pharm 1 stated administering Humalog 15 minutes before eating matches the peak action of when the Humalog insulin starts to work. Pharm 1 stated Humalog starts to work in 10 to 15 minutes. Pharm 1 stated that administering Humalog on an empty stomach has a risk that resident may experience hypoglycemia, because Humalog acts quickly and symptoms may include sweating, dizziness, confusion, and affect heart rate. Pharm 1 stated regardless of type of insulin, must alternate the injection site to prevent the development of lumps or scar tissue over time, which may delay or decrease absorption of the medication, creating unpredictable, inconsistent, and potentially not a complete absorption of the medication. According to DailyMed (the official U.S. government website that provides Food and Drug Administration-approved drug labeling and information), the manufacturer's labeling for Humalog dated 1/2026, indicated, Administer Humalog U-100 or U-200 by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Rotate injection sites to reduce risk of lipodystrophy (abnormal loss or buildup of fat tissue) and localized cutaneous amyloidosis (a condition where protein deposits called amyloid build up in the skin at repeated injection sites, leading to lumps or thickened areas).During a review of the facility's policy and procedures (P&P) titled, Insulin Administration, dated 3/2023, the P&P indicated, The nursing staff will have access to specific instructions (from manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.The three key characteristics of insulin are:Onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose;Peak effects - the time when the insulin is at its maximum effectiveness; andDuration of effects - the length of time during which the insulin is effective. Rapid-acting, onset 10-15 minutes.Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm) . Report excessive bruising, swelling, pain, redness, or unusual marks on or around the injection site. During a review of the facility's P&P titled, Administering Medications, dated 3/2023, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include.Enhancing optimal therapeutic effect of the medication. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 22) was provided interpreter to ensure the language used was understood. This deficient practice resulted in the resident not understanding instructions and had the potential to violate respect and dignity. Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes a person to have repeated seizures [brain sends abnormal electrical signals causing shaking, staring spells, confusion, loss of awareness, or unusual movements), hypertension (HTN, high blood pressure), dysphagia (difficulty swallowing), and anxiety disorder (a condition where a person feels very worried, nervous, or fearful more often and more strongly than normal).During a review of Resident 22's History and Physical (H&P) dated 7/22/2025, the H&P indicated Resident 22 had the capacity to make medical decisions.During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 22 was able to understand and be understood by others. The MDS indicated Resident 22's cognition (ability to think and process) was intact. The MDS indicated Resident 22 used a walker and wheelchair and required moderate assistance (helper does less than half the effort) from staff for activities of daily living and mobility. During a concurrent observation and interview on 5/19/2026 at 9:13 a.m. with the Licensed Vocational Nurse (LVN) 3, the LVN 3 called Resident 22 Poppa telling him to take blood pressure medication. Resident 22 was observed saying no while pointing to the two pills. LVN 3, called Resident 22 Poppa again but Resident 22 did not respond. LVN 3 stated she will contact a staff member to interpret and explain the medication to Resident 22. LVN 3 stated the importance in having a translator who speaks Spanish can help explain the type of medications, side effects, benefits, can answer questions in the resident's native language. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive care plans were developed and implemented for five (5) of 5 sampled residents (Residents 59, 1, 22, 50 and 92), by failing to ensure a comprehensive care plan was developed and implemented for:Resident 59's peripheral intravenous (IV) catheter (a thin, flexible tube inserted into a peripheral vein [small vein] to administer IV fluids and medications).Resident 1's heparin (blood thinner medicine) medication.Resident 22's influenza vaccine (shots to prevent infections) refusal and a care plan to address the resident's psychosocial needs identified in the comprehensive assessment. Resident 50 and Resident 92, who refused to wear the facility's identification (ID) bands. This failure had the potential for Residents 59, 1, 22, 50 and 92 to not receive the care and services necessary for safety and the potential to affect in maintaining the highest practicable physical and psychosocial wellbeing.Findings:<br><br>1). During a review of Resident 59's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 59 had diagnoses including encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), History of infectious (capable of being spread from one organism to another, usually caused by germs like viruses, bacteria, or fungi entering the body) and parasitic diseases (an illness caused by an organism that lives on or inside another organism and gets its nutrients at the host's expense), Cerebral Infarction (a condition where blood flow to the brain is interrupted, leading to damage or death of brain cells) , Thrombocytopenia (a medical condition characterized by an abnormally low number of platelets in your blood), and Dementia (loss of thinking, remembering, and reasoning).<br><br>During a review of Resident 59's Minimum Data Set (MDS- a resident assessment tool), dated 3/1/2026, the MDS indicated Resident 59's cognitive skills for daily decision making were severely impaired. Resident 59 was dependent on staff for eating, oral and toileting hygiene, bathing, upper & lower body dressing, and personal hygiene.<br><br>During a review of the Care Plan Report, dated 3/16/2026, the Care Plan Report did not indicate any care plans for Resident 59's peripheral IV (PIV).<br><br>During a review of the Resident 59's Order Summary Report, dated 5/11/2026, the Order Summary Report did not indicate an order to maintain or discontinue Resident 59's PIV and had no order for IV hydration.<br><br>During a review on 5/21/2026 at 11:51 am, Resident 59's admission Orders, dated 5/11/2026 did not include an order for PIV care, use, or monitoring.<br><br>During a concurrent interview and record review on 5/19/2026 at 2:30 p.m., at the Station 2 desk, with Registered Nurse Supervisor (RNS) 2, Resident 59's Care Plan Report dated 3/16/2026, was reviewed. RNS 2 stated Resident 59 had no care plan for the PIV upon admission to ensure the PIV site was monitored for infection, swelling or pain. RNS 2 stated if there was no care plan, there was a risk that care would not be provided to Resident 59. RNS 2 stated care plans are important to guide staff on what to assess and to achieve the goal of therapy.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. During a review of Resident 1's Face Sheet, the face sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated Resident 1's diagnoses included chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), dysphagia (difficulty swallowing), pneumonia (an infection/inflammation in the lungs) and encephalopathy (damage or disease that affects the brain).<br><br>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/30/2026, the MDS indicated Resident 1's cognitive (thinking) skills were severely impaired. The MDS indicated Resident 1 was dependent on staff members with Activities of Daily Living (ADLs).<br><br>During a review of Resident 1's History and Physical form (H&P), dated 5/15/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1's physician orders, dated 5/15/2025, the physician orders indicated Heparin Sodium 5000 units per milliliter, to inject 5000 international units subcutaneously two times a day for deep vein thrombosis (a serious condition characterized by the formation of a blood clot in a deep vein) prophylaxis.<br><br>During a review of Resident 1's care plan, there was no care plan noted for Resident 1's Heparin medication.<br><br>During a concurrent interview and record review, on 5/21/2026 at 11:05 a.m., with Registered Nurse 1 (RN 1), Resident 1's care plan for heparin was reviewed. RN 1 stated she did not see a care plan for Resident 1's heparin medication. RN 1 stated the risk for not initiating a care plan for the heparin use could result in not being able to monitor for any complications and/or not following the protocol for medications.<br><br>3). During a review of Resident 22's Face Sheet, the Face Sheet indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including epilepsy (a neurological disorder characterized by recurring, unprovoked seizures), anxiety (a feeling of fear and dread), and hypertension (HTN-high blood pressure).<br><br>During a review of Resident 22's History and Physical (H&P), dated 7/22/2025, the H&P indicated Resident 22 had the capacity to make medical decisions.<br><br>During a review of Resident 22's Minimum Data Set (MDS – a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 22's cognition (the ability to think and process information) was intact. The MDS indicated Resident 22 was independent (resident completes the activity by themselves) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).<br><br>3a) During a concurrent interview and record review on 5/20/2026 at 1:15 p.m. with the Director of Staff Development (DSD), Resident 22's medical record was reviewed. The DSD stated the Resident 22, speaks Spanish, did not have a care plan to address the resident's language and psychosocial needs. The DSD stated the interdisciplinary team (healthcare professionals who work together to plan, provide, and evaluate a resident's care) should have addressed and evaluated the care plan to ensure interventions are present to meet Resident 22's communication needs.<br>(continued on next page) |

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| | 555719 | A. Building<br>B. Wing | 05/22/2026 |

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| Imperial Crest Health Care Center | 11834 Inglewood Avenue<br>Hawthorne, CA 90250 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3b) During a review of Resident 22's physician order, dated 8/18/2023, the physician order indicated to administer influenza vaccine annually between October and March.<br><br>During a concurrent interview and record review on 5/21/2026 at 10:37 a.m., with the Infection Preventionist (IP), Resident 22's immunization record for the 2025- 2026 influenza season was reviewed. The immunization record did not indicate Resident 22 received the annual influenza vaccine for the 2025 -2026 influenza season. The IP stated Resident 22's immunization record indicated the resident refused the influenza vaccine. The IP stated when a resident refuse the influenza vaccine, licensed staff should develop a comprehensive person-centered care plan with measurable interventions specific for the resident's needs.<br><br>During a concurrent interview and record review on 5/21/2026 at 11:00 a.m., with the IP, Resident 22's care plan, dated 2025 to 2026, for influenza vaccine and/or influenza vaccine refusal was reviewed. The IP stated there was no care plan developed for Resident 22's influenza vaccine refusal. The IP stated Resident 22 should have an individualized care plan for influenza vaccine refusal, with interventions developed to guide nurses on how to provide education, monitor for continued refusal, and implement infection prevention measures as appropriate. The IP stated this failure had the potential to place Resident 22 at risk for influenza infection and related complications, including respiratory illness, dehydration, hospitalization, and increased risk of serious illness or death.<br><br>4. During an interview on 5/20/2026 at 8:15 a.m. with the Admissions Director (AD), the AD stated during rounds (routine checks made by a manager to observe residents, staff, and the environment to ensure safety, quality of care, and proper operations) on 5/8/2026, the AD observed Resident 50 and Resident 92 who were sitting on bed in their respective resident's room had no ID band. The AD stated Resident 50 and Resident 92 had refused to wear an ID band on the wrist but did not inform nursing staff or Social Services regarding the resident's refusal. The AD stated nursing should have been informed because an ID band was required as a patient identifier for medication administration and treatments. Social Services should have been notified for alternatives, document the refusal, and develop a comprehensive plan of care for accurate resident identification, timely delivery of care address resident's preferences and respected while reducing the risk of error.<br><br>During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes a person to have repeated seizures [brain sends abnormal electrical signals causing shaking, staring spells, confusion, loss of awareness, or unusual movements), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), transient ischemic attack (condition when blood flows to part of the brain is blocked for a short time), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).<br><br>During a review of Resident 50's History and Physical (H&P) dated 8/12/2025, the H&P indicated Resident 50 had the capacity to understand make medical decisions.<br><br>During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 50 was able to understand and be understood by others. The MDS indicated Resident 50's cognition (ability to think and process) was intact. The MDS indicated Resident 50 required substantial assistance (helper does more than half the effort) from staff for activities of daily living and mobility.<br><br>During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 92's diagnoses included encephalopathy (a condition where the brain is not working normally because it has been affected by an illness, injury, infection, lack of oxygen, or problems with the body's organs), emphysema (a lung disease that damages the lungs and makes it difficult to breathe), hypertension (HTN, high blood pressure), anemia (a condition where the body does not have enough healthy red blood cells), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).<br><br>During a review of Resident 92's H&P dated 12/19/2025, the H&P indicated Resident 92 does not have the capacity to understand and make decisions. Resident 92 was able to make decisions for activities of daily living.<br><br>During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92 was able to understand and be understood by others. The MDS indicated Resident 92's cognition (ability to think and process) was intact. The MDS indicated Resident 92 used a walker and wheelchair and require supervision or touching assistance (helper provides verbal cues and/or touching) may be provided from staff for activities of daily living and mobility.<br><br>During a concurrent interview and record review on 5/20/26 at 1:34 p.m. with Registered Nurse Supervisor (RNS 1), Resident 50's medical record was reviewed. RNS 1 stated there was no documentation by Social Services Director (SSD), the Minimum Data Set Coordinator Director (MDS), and nursing about Residents 50 and 92's refusal to wear an ID band. RNS1 stated the importance of knowing if a resident refuses wearing an ID band can lead to medication administration errors, treatment and procedure errors, delay in care, and lack of consistent staff approach.<br><br>During an interview on 5/20/2026 at 8:55 a.m. with the SSD, the SSD stated she was not informed of Residents 50 and 92's refusal to wear an ID band. The SSD stated when informed of a residents' refusal to wear an ID band, the SSD meets with the resident to explain the benefits and identify an alternative method to identify the resident. The SSD stated the residents' refusal is discussed during the plan of care meeting and documented in the progress notes in the resident's medical record.<br><br>During an interview on 5/20/2026 at 9:00 a.m. with the MDS, the MDS stated she did not update Residents 50 and 92's care plan regarding the resident's refusal to wear an ID band on 5/8/2026 and was updated on 5/19/2026. The MDS stated that when a resident does not wear an ID band, it creates safety concern because staff may misidentify the resident, which can lead to medication administration errors, treatment errors and an incomplete plan of care.<br><br>During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated the facility should develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure care plans for two of ten residents (Resident 41 and Resident 58) were reviewed and updated quarterly as indicated in the facility's policy and procedures (P&P) titled, Comprehensive Person-Centered Care Plans.This failure had the potential to affect the residents' care and interventions to address the problems will not be implemented.Findings: 1). During a review of Resident 41's Face Sheet, the Face Sheet indicated Resident 41 had chronic respiratory failure (long-term, ongoing condition where the lungs cannot properly exchange oxygen and carbon dioxide), history of pneumonia (an infection that inflames the air sacs in one or both lungs), and a tracheostomy (surgical opening in the neck airway to establish airway). During a review of Resident 41's History & Physical (H&P), dated 3/14/2026, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Minimum Data Set (MDS- a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 41 was dependent on staff for personal hygiene, toileting hygiene, bathing, rolling left to right and back, and getting dressed. During a review of Resident 41's Care Plan Report titled, Respiratory Care, initiated on 10/11/2022, the care plan was last revised on 7/1/2024 and had a target date of 6/24/2026. 2). During a review of Resident 58's Face Sheet, the Face Sheet indicated Resident 58 was admitted to the facility on [DATE], with diagnoses including schizophrenia (a chronic, severe brain disorder that causes people to interpret reality abnormally, often resulting in hallucinations, delusions, and disorganized thinking) and dementia (loss of thinking, remembering, and reasoning). During a review of Resident 58's H&P dated 9/7/2025, the H&P indicated Resident 58 does not have the capacity for medical decision making due to mild cognitive (mental processes involved in knowing, learning, and understanding) impairment of uncertain or unknown etiology (the cause, set of causes, or origin of a disease or condition). During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58 had moderate cognitive impairment. The MDS indicated Resident 58 was dependent on staff for eating, personal hygiene, upper/lower body dressing, and rolling left to right in bed. During a review of Resident 58's Care Plan Report, the report indicated the following: The care plan titled, Behaviors. Alteration in behavior patterns, initiated on 6/12/2024, was last revised 4/3/2025. The care plan had a target date of 6/14/2026. The care plan titled, GT Feeding. At risk for aspiration, dehydration, weight fluctuation, nausea and vomiting, abdominal distention, intolerance to feeding and GT site infection, initiated 4/3/2025, was last revised on 1/20/2026. The care plan had a target date of 6/14/2026 During an interview on 5/21/2026 at 1:32 p.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated care plans should be updated/ revised every three months, upon admission and readmission to provide continuity of care. If there were increase in resident's behavioral episodes, or residents' behaviors were resolved, the care plan should be updated of the resident's current condition. If care plans were not updated of the resident's current condition, resident care will be affected and will not be addressed. During a concurrent interview and record review on 5/21/2026, at 2:06 p.m., with the MDS Coordinator, Resident 41's care plan titled Respiratory Care, initiated on 10/11/2022, last revised 7/1/2024 with a target date of 6/24/2026 and Resident 58's care plans titled Behaviors. Alteration in behavior patterns, initiated 6/12/2024, last revised 4/3/2025, with a target date of 6/14/2026 and GT Feeding. At risk for aspiration, dehydration, weight fluctuation, nausea and vomiting, abdominal distention, intolerance to feeding and GT site infection, initiated 4/3/2025, last revised 1/20/2026 with a target date of 6/14/2026 were reviewed. The MDS Coordinator stated Resident 41's and Resident 58's care plan were not updated quarterly. The MDS coordinator stated if the residents' care plans were not updated, the residents' plan of care and appropriate interventions would be affected. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, dated 3/2022, the P&P indicated, the interdisciplinary team should review and update the care plan at least quarterly. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure effective communication services and language assistance were provided to one of five sampled residents (Resident 22). This deficient practice had the potential to prevent accurate communication between Resident 22 and facility staff, resulting in unmet needs, delayed intervention, and increased risk for resident harm. Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes a person to have repeated seizures [brain sends abnormal electrical signals causing shaking, staring spells, confusion, loss of awareness, or unusual movements), hypertension (HTN, high blood pressure), dysphagia (difficulty swallowing), and anxiety disorder (a condition where a person feels very worried, nervous, or fearful more often and more strongly than normal). During a review of Resident 22's History and Physical (H&P) dated 7/22/2025, the H&P indicated Resident 22 had the capacity to make medical decisions. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 22 was able to understand and be understood by others. The MDS indicated Resident 22's cognition (ability to think and process) is intact. The MDS indicated Resident 22 used a walker and wheelchair and required moderate assistance (helper does less than half the effort) from staff for activities of daily living and mobility. During a concurrent observation and interview on 5/19/2026 at 9:13 a.m. with Licensed Vocational Nurse (LVN) 3, the LVN 3 was arguing with Resident 22 to take blood pressure medication. Resident 22 was saying no, while pointing to the two pills. LVN 3 stated that she (LVN3) understands Spanish and Resident 22 understands English. Resident 22 stated in Spanish to the LVN he does not recognize the two pills. LVN 3 stated she did not understand what Resident 22 said. Resident 22 did not respond to LVN 3. LVN 3 stated she will contact a Spanish speaking staff member to interpret. The Spanish speaking staff member interpreted and explained the medications to Resident 22. LVN 3 stated it was important to have a translator who speaks Spanish to help answer questions, explain to the Spanish speaking resident (Resident 22) the type of medications, side effects, and the benefits in the language Resident 22 understands. During an interview an interview on 5/21/2026 at 10:14 a.m. with the Director of Nursing (DON), the DON stated she was not aware LVN 3 was not utilizing the facility's resources to communicate to residents who speak Spanish. The DON stated Social Services provides a communication board. The DSD conducts staff training on the available resources such as an in-house interpreter, and a phone application to assist staff to interpret. The DON stated that when staff do not use the facility's resources, it can compromise the resident's ability to communicate choices and concerns which can violate a resident's rights to dignity and self-determination. During a record review of the facility's policy and procedure (P&P) titled, Policy: Accommodation of Needs Related to Communication Deficits, undated, the P&P indicated the facility is committed to identifying communication needs and appropriate interventions. The facility will assess the communication needs of residents by means of a psychosocial assessment form to identify language spoken, and a care plan will be developed, updated quarterly and as indicated to reflect accurate, current assessments related to communication needs. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician's order was obtained to keep the peripheral intravenous (PIV) line, of one of ten residents (Resident 59), and ensure the IV dressing was dated.This failure placed the resident at risk for IV site infection.Findings:During a review of Resident 59's Face Sheet, the Face Sheet indicated Resident 59 had diagnoses including encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of infectious and parasitic diseases (illnesses caused by organism that lives in or on an organism of another species (its host) and benefits by deriving nutrients at the other's expense), cerebral infarction (stroke), thrombocytopenia (a condition characterized by an abnormally low number of platelets in the blood) and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's Minimum Data Set, MDS, dated [DATE], the MDS indicated Resident 59's cognitive (mental processes involved in knowing, learning, and understanding) skills for daily decision making was severely impaired. Resident 59 was dependent on staff's assistance for eating, oral and toileting hygiene, bathing, upper & lower body dressing, and personal hygiene. During a review of Resident 59's Order Summary Report, dated 5/11/2026, the Order Summary Report did not indicate an order to maintain or discontinue Resident 59's PIV. Resident 59 did not have a physician's order for IV infusions. During an observation on 5/19/2026 at 10:41 a.m., in Resident 59's room, Resident 59 was observed with a PIV on the right hand, with an undated IV dressing. During a concurrent observation and interview on 5/19/2026 at 1:39 p.m., with Licensed Vocational Nurse (LVN) 1 in Resident 59's room, LVN 1 stated Resident 59's PIV dressing was not dated. LVN 1 stated the licensed staff should monitor the PIV site for signs of infiltration, skin discoloration due to the risk of infection. During an observation and interview on 5/19/2026 at 2:27 p.m., with RNS 1, Registered Nurse Supervisor (RNS 1), RNS 1 stated it was important to know when the IV dressing was changed to prevent an infection. During a review of the Medication Administration Record (MAR), for the month of 5/2026, the MAR indicated Resident 59 completed the order of Dextrose with Sodium Chloride Intravenous Solution 5-0.45% started 5/5/2026, on 5/7/2026. The MAR indicated checking the IV site every shift was discontinued on 5/8/2026. During an interview on 5/22/2026 at 11:31 a.m. with the DON, the DON stated facility staff should have obtained a physician's order to keep the PIV, assess and to monitor for signs of infections. During a review of the facility's policy and procedure (P&P) titled, General Policies for IV Therapy, dated 3/2023, the P&P indicated IV peripheral sites will be rotated when clinically indicated (e.g. unresolved complication, discontinuation of infusion therapy or when no longer necessary for the plan of care). Dressing change is performed at least every 7 days and when needed. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain medication one of seven sampled residents (Resident 11), were available and did not miss four doses of scheduled pain medications.This deficient practice had the potential to result in the resident not receiving pain medicine timely, pain not being managed and placing the resident at risk for severe pain, including hospitalization.Findings: During a review of Resident 11's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 11 was initially admitted on [DATE] and readmitted on [DATE]. Resident 11's diagnoses included colon cancer (a disease where cells in the large intestine grow out of control and form tumors), polyneuropathy (a medical condition where many nerves outside the brain and spinal cord (the peripheral nerves) are damaged at the same time), chronic pain syndrome (persistent pain lasting longer than 3 to 6 months) and sepsis (a life-threatening blood infection).During a review of Resident 11's History and Physical form (H&P), dated 8/18/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 11's cognitive (thinking) skills were cognitively intact. The MDS indicated Resident 11 required substantial assistance from staff members with Activities of Daily Living (ADLs). During a review of Resident 11's current physician orders, the physician orders indicated the following:Administer Suboxone 8-2 milligrams (mg, a unit of measurement), sublingually (under the tongue) two times a day (9:00 a.m. and 6:00 p.m.) for chronic pain syndrome. Administer Pregabalin 25 mg three times (10:00 a.m., 2:00 p.m. and 10:00 p.m.) by mouth for chronic neuropathic pain. During a review of Resident 11's electronic MAR for the months of April and May 2026, the MAR indicated on 4/16/2026 and 4/25/2026, Resident 11 did not receive 10:00 a.m. and 2:00 p.m. doses of Pregabalin 25mg and the 2:00 p.m. dose on 5/1/2026. During a review of Resident 11's progress notes, dated 4/16/2026 and 4/25/2026, the progress note indicated Resident 11 did not receive the Pregabalin 25mg because the medication was unavailable. The facility was waiting for delivery from the pharmacy. During a review of Resident 11's electronic Medication Administration Review (MAR-an official, legal document used in healthcare facilities to track all the drugs administered to a patient) for the month of 5/2026, the MAR indicated on 5/11/2026, Resident 11 did not receive the 6 p.m. dose of Suboxone. During a review of Resident 11's progress notes, dated 5/18/2026, the progress note indicated Resident 11 did not receive the 6 p.m. dose of Suboxone. The progress notes indicated Suboxone was unavailable and the facility was waiting for pharmacy delivery. During a concurrent interview and record review, on 5/21/2026 at 11:25 a.m., with Registered Nurse 1 (RN 1), RN 1 stated if there's a new physician's order of pain medication, the facility will notify the pharmacy. RN 1 stated the facility protocol is that if a resident ran out of pain medications and the resident was in pain, the licensed nurse should call the pharmacy to obtain code to open the facility's emergency kit. RN 1 stated when Resident 11's pregabalin was not available and not administered to Resident 11 for 4 doses, the e-kit was not opened. The pregabalin was not administered to Resident 11 for 4 doses. RN 1 stated pain medications should have been refilled a week prior to running out. RN 1 stated the risk of not refilling routine pain medications prior to running out could result in a resident to suffer unrelieved pain and emotional. During a review of the facility's policy and procedures (P&P), titled Pain Management, dated 3/2023, the P&P indicated drugs and biologicals that are required to be refilled, must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct monthly Medication Regimen Review (a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) of one of five sampled residents' (Resident 50) medical record. This failure had the potential for the facility to not identify irregularities, significant risks, or actual or potential adverse consequences which may result from or be associated with the resident's current medication. This failure had the potential to affect in maintaining the resident's highest practicable level of physical, mental and psychosocial wellbeing.Findings: During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes a person to have repeated seizures [abnormal electrical activity in the brain]), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), transient ischemic attack (condition when blood flows to part of the brain is blocked for a short time), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 50's History and Physical (H&P) dated 8/12/2025, the H&P indicated Resident 50 had the capacity to understand make medical decisions. During a review of Resident 50's [NAME] Data Set (MDS, a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 50 was able to understand and be understood by others. The MDS indicated Resident 50's cognition (ability to think and process) was intact. The MDS indicated Resident 50 required substantial assistance (helper does more than half the effort) from staff for activities of daily living and mobility. During a concurrent interview and record review on 5/21/26 at 9:28 a.m. with Registered Nurse Supervisor (RNS 1), Resident 50's medical record was reviewed. RNS 1 stated Resident 50's Medication Regimen Review was not conducted in January 2026, February 2026, March 2026, and April 2026 for the Fluoxetine (medication for depression) 30 milligram (mg, metric unit of measurement, used for medication dosage and/or amount), Trazadone (medication for psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality] insomnia and depression) 50 mg, Risperidone (medication for mood disorder and for extreme fear) 1mg, and Risperdal (a medication for psychosis and mood disorder) 0.5mg. RNS 1 stated Resident 50's antipsychotic medications should have been reviewed by the Pharmacy Consultant to ensure gradual dosage reduction (GDR) was discussed, medication dosage was therapeutic (helps a person heal, recover, or feel better physically, mentally, or emotionally), behaviors laboratory levels were monitored to ensure efficacy (a measure of how effective something is doing and what it is supposed to do) of the medications. During a review of the facility's policy and procedure (P&P) titled, IIIA1a: Medication Regimen Review (Monthly Report), dated 6/2021, the P&P indicated the facility is committed to evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The P&P indicated the consultant pharmacist reviews the MRR of each resident at least monthly, or a more frequent MRR may be deemed necessary if the medication regimen is thought to contribute an acute change in condition or adverse consequence, and recommendations are acted upon and documented by the facility staff and / or the prescriber. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555719 | A. Building<br>B. Wing | 05/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Imperial Crest Health Care Center | 11834 Inglewood Avenue<br>Hawthorne, CA 90250 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment for three of three sampled residents (Residents 103, 41, and 54) by failing to ensure:1). Humidifier bottles (devices used with oxygen to add moisture to the oxygen being delivered, enhancing comfort and effectiveness during oxygen therapy) and oxygen tubings were dated when changed. 2). Resident 54, who had a tracheostomy (a surgical opening in the neck for an airway) tube and with mouth open, had a room free of flies.These failures had the potential to cause cross contamination and placed Residents 103, 41, and 54 at risk for infections.Findings:<br><br>During an observation and interview on 5/19/2026 at 10:01 a.m., in Residents 103 and 41's room, with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the residents' humidifier bottles and tubing were not dated. RNS 2 stated if the humidifier bottle and tubing were not dated, the facility staff would not know when to change them. RNS 2 stated the humidifier bottles and tubing should be changed weekly. If they are not changed, organisms could grow and the resident could be at risk for an infection.<br><br>a). During a review of Resident 103's Face Sheet, the Face Sheet indicated Resident 103 had the diagnoses of sleep apnea (temporary suspension of breathing), diaphragmatic hernia (condition in which abdominal organs push through an abnormal opening in the diaphragm into the chest cavity, potentially impairing lung development and function) and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures).<br><br>During a review of Resident 103's History & Physical (H&P), dated 5/18/2026, the H&P indicated Resident 103 had the capacity to understand and make decisions.<br><br>b). During a review of Resident 41's Face Sheet, the Face Sheet indicated Resident 41 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Face Sheet indicated Resident 41 had Chronic Respiratory Failure, history of pneumonia (lung infection), and a tracheostomy.<br><br>During a review of Resident 41's H&P, dated 3/14/2026, the H&P indicated Resident 41 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognitive skills for daily decision making was severely impaired. Resident 41 was dependent with staff for personal, oral hygiene, toileting hygiene, shower and bathing self, upper and lower body dressing, and in putting on/ taking off footwear.<br><br>c). During a review of Resident 54's Face Sheet, the Face Sheet indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 54's diagnoses included chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), tracheostomy tube, gastronomy tube (a soft medical tube inserted directly through a small opening in the belly into the stomach) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 54's H&P dated 3/20/2026, the H&P indicated Resident 54 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54's cognitive (continued on next page) |

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| | 555719 | A. Building<br>B. Wing | 05/22/2026 |

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| Imperial Crest Health Care Center | 11834 Inglewood Avenue<br>Hawthorne, CA 90250 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (thinking) skills were severely impaired. The MDS indicated Resident 8 was dependent on staff with ADLs.<br><br>During an observation, on 5/19/2026 at 10:39 a.m., in Resident 54's room, a housefly was observed in the room and landed on Resident 54's right hand and left side of the cheek near her mouth. Resident 54 who was non-verbal (unable to speak) and bedbound, was observed with mouth wide open, had a tracheostomy tube and gastronomy tube.<br><br>During a concurrent observation and interview, on 05/20/2026 at 1:30 p.m., with the Respiratory Therapist 1 (RT 1), in the Conference Room, RT 1 confirmed a housefly was observed flying around the conference room. RT 1 stated houseflies were known to carry bacteria, viruses and potential parasites and had the potential to cause infections to residents with tracheostomy and gastronomy tubes by laying eggs, causing maggots to form in the openings.<br><br>During a review of the facility's policy and procedures (P&P), titled Policies and Practices- Infection Control, dated 10/2018, the P&P indicated the facility should maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.<br><br>During a review of the facility's policy and procedures (P&P), titled Pest Control, dated 5/2008, the P&P indicated the facility should maintain an on-going pest control program to ensure that the building is kept free of insects and rodents. |