STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055032	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Earlwood	20820 Earl Street Torrance, CA 90503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to notify the physician when a resident experienced a change of condition([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) for four of five sampled residents (Resident 1, 2, 3 and 4). The facility failed to: 1. Ensure licensed nurses notified Resident 1, 2, 3 and 4 ' s physician when Resident 1, 2, 3 and 4 did not receive their 9:00 a.m. scheduled medications on 4/19/2025. 2. Ensure licensed nurses documented a COC when schedule medications were not administered to Resident ' s 1, 2, & 4 on 4/19/2025 at 9 a.m. These deficient practices of not notifying the physician of the residents COC resulted in a delay of evaluation, care, treatment, and monitoring. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to part of the brain), atrial fibrillation (irregular and often very rapid heart rhythm), hypertension (HTN- high blood pressure), and pancytopenia (a lower-than-normal number of red and white blood cells and platelets in the blood). During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool) dated 3/21/2025 indicated Resident 1 ' s cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting and bathing. During a review of Resident 1 ' s Medication Administration Record (MAR), the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (a cancerous tumor) of the right breast and bone and thrombocytopenia (low blood platelet count). During a review of Resident 2 ' s MDS dated [DATE], Resident 2 ' s cognition was intact and required moderate assistance with toileting and dressing. During a review of Resident 2 ' s MAR, the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD- a slow progressive narrowing of the blood flow to the arms and legs), and cerebrovascular disease (condition that affects the blood vessels and blood flow to the brain, potentially leading to a stroke {loss of blood flow to part of the brain}). During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognition was intact and required moderate assistance with toileting and dressing. During a review of Resident 3 ' s Medication Administration Record (MAR), the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including myocardial infarction (MI-heart attack), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing a difficulty in breathing). During a review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 ' s cognition was intact and required moderate assistance with toileting, bathing, and dressing. During a review of Resident 4 ' s MAR, the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During a concurrent interview and record review on 4/23/2025 at 1:53 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 indicated Resident 1 and Resident 4 ' s MAR was marked as red on 4/19/2025 at 9:00 a.m., indicating their medications were not administered. LVN 1 stated she was unable to locate documentation that Resident 1 or Resident 4 ' s physician was notified, or a COC was initiated. LVN 1 stated that when medications were not administered at the scheduled time, the physician should be notified, and a COC should be documented to ensure the residents receive accurate monitoring and prevent hospitalization . During an interview on 4/23/2025 at 3:56 p.m., with LVN 4, LVN 4 stated when medications were not administered at their scheduled time, the resident ' s physician should be notified, and a COC should be documented because the resident could experience an adverse reaction to missing a dose of their medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 3:18 p.m., with the facility pharmacist (FP), the FP stated that anytime a medication was missed, the physician should be notified in case there needs to be close monitoring, laboratory blood draws, or frequent vital signs ordered. During an interview on 4/24/2025 at 4:36 p.m., with the Director of Nursing (DON), the DON stated if she was made aware of the missed medications on 4/19/2025 at 9:00 a.m. residents affected physicians and representatives will be informed. The DON stated at the time this occurred, the physicians should have been notified immediately, and a COC should have been documented but was not done. The DON stated missing the medications could potentially cause adverse outcomes such as hypertension, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and/or development of blood clots, depending on the medication missed. During a review of the facility ' s LVN Job Description, revised 5/2022, the LVN Job Description indicated, Administer medications within the scope of practice and according to practitioner orders. Report adverse consequences, side effects, or any medication errors. During a review of the facility ' s policy and procedure (P&P) titled, Change in Condition: Notification of, dated 8/25/2021, the P&P indicated, Purpose is to ensure residents, family, legal representatives, and physicians are informed of changes in the resident ' s condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to have sufficient staffing on 4/19/2025 when one licensed nurse called off and one no call no show (an employee fails to report to work as scheduled and fails to notify their employer of their absence) to accommodate resident needs in administering medications timely. This deficient practice resulted in Resident 1, 2, 3 and 4 not receiving all scheduled medications on 4/19/2025 at 9 a.m. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to part of the brain), atrial fibrillation (irregular and often very rapid heart rhythm), hypertension (HTN- high blood pressure), and pancytopenia (a lower-than-normal number of red and white blood cells and platelets in the blood). During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool) dated 3/21/2025 indicated Resident 1 ' s cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting and bathing. During a review of Resident 1 ' s Medication Administration Record (MAR), the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (a cancerous tumor) of the right breast and bone and thrombocytopenia (low blood platelet count). During a review of Resident 2 ' s Minimum Data Set (MDS- resident assessment tool) dated 3/24/2025 indicated Resident 2 ' s cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting and dressing. During a review of Resident 2 ' s Physician Order Details dated 2/24/2025, the Physician Order Details indicated Resident 2 ' s order for Anastrozole (a medication to treat breast cancer) to be administered at 8:00 a.m. daily. During a review of Resident 2 ' s Administration Details Report for the month of April 2025, the Administration Details Report indicated 10 out of 24 days for the month of April, the medication Anastrozole was administered late (after 10:00 a.m.). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD- a slow progressive narrowing of the blood flow to the arms and legs), and cerebrovascular disease (condition that affects the blood vessels and blood flow to the brain, potentially leading to a stroke {loss of blood flow to part of the brain}). During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognition was intact and required moderate assistance with toileting and dressing. During a review of Resident 3 ' s Medication Administration Record (MAR), the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including myocardial infarction (MI-heart attack), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing a difficulty in breathing). During a review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 ' s cognition was intact and required moderate assistance with toileting, bathing, and dressing. During a review of Resident 4 ' s MAR, the MAR indicated the scheduled 9:00 a.m. medications on 4/19/2025 were not administered. During an interview on 4/23/2025 at 9:00 a.m., with Resident 2 stated there were times she does not receive her 8:00 a.m. medication until 10:00 a.m. or 12:00 p.m. Resident 2 stated not receiving her 8:00 a.m. medication on time causes her to feel upset and stressed because the medication was important to take on time as prescribed. During an interview on 4/24/2025 at 11:59 a.m. with Resident 4, Resident 4 stated there was a day recently (unknown date) she did not receive her morning medications and there were some days her morning medications were given late. Resident 4 stated not receiving her medications concerns her because she needs her medications, especially her blood thinning medication. During an interview on 4/24/2025 at 2:06 p.m., with Resident 3, Resident 3 stated this past weekend he did not receive his 9:00 a.m. medications until 1:47 p.m. Resident 3 stated the facility was short staffed because there were days, he receives his medications several hours late and some days he will not see his nurse until noon. During an interview on 4/24/2025 at 4:36 p.m., with the Director of Nursing (DON), the DON stated she was responsible for the licensed nurses schedules and this weekend there was a sick call and no call no show. The DON stated it was her responsibility to cover when licensed staff call off. The DON stated she should have come this past weekend (4/19/2025). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled, Staffing, undated, the P&P indicated, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. During a review of the facility ' s Director of Nursing Job Description revised 10/2020, the Director of Nursing Job Description indicated the duties included, Determine the staffing needs of the nursing services department necessary to meet the total nursing needs of the resident population.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49145 Based on interview and record review, the facility failed to ensure four of five sampled resident (Resident 1,2, 3, and 4) medications were administered within one hour of their scheduled administration time in accordance with the facility ' s policy and procedures titled Administering Medications, (undated). These deficient practices placed Residents 1, 2, 3, and 4, at risk to experience medication adverse reactions, and complications including a high blood pressure leading to stroke (damage to the brain from interruption of its blood supply), venous thromboembolism (blood clots in the veins), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and hospitalization . Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to part of the brain), atrial fibrillation (irregular and often very rapid heart rhythm), hypertension (HTN- high blood pressure), and pancytopenia (a lower-than-normal number of red and white blood cells and platelets in the blood). During a review of Resident 1 ' s Minimum Data Set (MDS- resident assessment tool) dated 3/21/2025 indicated Resident 1 ' s cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting and bathing. During a review of Resident 1 ' s Medication Administration Record (MAR), the MAR indicated Resident 1 ' s scheduled 9:00 a.m. medications on 4/19/2025 were not administered. The medications were as follows: 1. one tablet of apixaban (a medication used to treat atrial fibrillation) 2.5 milligrams (mg- a unit of measurement for mass). 2. one tablet of losartan potassium (a medication used to treat HTN) 50 mg. 3. one tablet of metoprolol succinate (a medication used to treat HTN) 0.5 mg. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (a cancerous tumor) of the right breast and bone and thrombocytopenia (low blood platelet count). During a review of Resident 2 ' s MDS dated [DATE], Resident 2 ' s cognition was intact and required moderate assistance with toileting and dressing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Physician Order Details dated 2/24/2025, the Physician Order Details indicated Resident 2 ' s order for Anastrozole (a medication to treat breast cancer) to be administered at 8:00 a.m. daily. During a review of Resident 2 ' s Administration Details Report for the month of April 2025, the Administration Details Report indicated 19 out of 24 days for the month of April, the medication Anastrozole was administered late (after 9:00 a.m.). During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD- a slow progressive narrowing of the blood flow to the arms and legs), and cerebrovascular disease (condition that affects the blood vessels and blood flow to the brain, potentially leading to a stroke {loss of blood flow to part of the brain}). During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognition was intact and required moderate assistance with toileting and dressing. During a review of Resident 3 ' s MAR, the MAR indicated Resident 3 ' s scheduled 9:00 a.m. medications on 4/19/2025 were not administered. The medications were as follows: 1. one tablet of benazepril (a medication used to treat HTN) 20 mg. 2. one tablet of gabapentin (a medication used to treat neuropathy [when nerve damage leads to pain, weakness, numbness or tingling in one or more parts body parts]) 300mg. 3. one tablet of Jardiance (a medication used to treat DM) 25 mg. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including myocardial infarction (MI-heart attack), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing a difficulty in breathing). During a review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 ' s cognition was intact and required moderate assistance with toileting, bathing, and dressing. During a review of Resident 4 ' s MAR, the MAR indicated Resident 4 ' s scheduled 9:00 a.m. medications on 4/19/2025 were not administered. The medications were as follows: 1. two tablets of acetaminophen (a medication used to treat pain) 325 mg. 2. one inhalation of advair diskus (a medication used to treat COPD) 250-50 mg. 3. one tablet of aspirin (a medication used for stroke prevention) 81 mg. 4. one inhalation of budesonide (a medication used to treat COPD) 0.5 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. one tablet of bupropion (a medication used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest]) 75 mg. 6. one tablet of carvedilol (a medication used to treat HTN) 3.125 mg. 7. one tablet of clopidogrel bisulfate (a medication used for blood clot prevention) 75 mg. 8. one tablet of folic acid (a medication used to treat low folate levels) 1 mg. 9. one scoop of glycolax powder (a medication used for bowel management) 17 grams (gm- a unit of measure for mass). 10. one tablet of Lasix (a medication used to treat congestive heart failure [CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling]) 20 mg. 11. one tablet of levetiracetam (a medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 750 mg. 12. one tablet of sacubitril-valsartan (a medication used to treat CHF) 24-26 mg. 13. one tablet of sertraline (a medication used to treat major depressive disorder) 50 mg. 14. Half a tablet of spironolactone (a medication used to treat HTN and CHF) 25 mg. During an interview on 4/23/2025 at 9:00 a.m., with Resident 2 stated there were times she does not receive her 8:00 a.m. medication until 10:00 a.m. or 12:00 p.m. Resident 2 stated not receiving her 8:00 a.m. medication on time causes her to feel upset and stressed because the medication was important to take on time as prescribed. During a concurrent interview and record review on 4/23/2025 at 1:53 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Residents 1 and 4 did not receive their 9:00 a.m. schedule medications on 4/19/2025 as indicated in residents MAR marked red which indicated it was not given. LVN 1 stated if a resident missed a blood thinning medication, the resident could develop a blood clot, become hospitalized and potentially die. During an interview on 4/23/2025 at 3:56 p.m., with LVN 4, LVN 4 stated if a resident missed a blood pressure medication, the resident could become hypertensive and if they miss a blood thinning medication, the resident could develop a clot, potentially have a stroke and die. During an interview on 4/24/2025 at 11:59 a.m. with Resident 4, Resident 4 stated there was a day recently (unknown date) she did not receive her morning medications and there were some days her morning medications were given late. Resident 4 stated not receiving her medications concerns her because she needs her medications, especially her blood thinning medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 2:06 p.m., with Resident 3, Resident 3 stated this past weekend (4/19/2025) he did not receive his 9:00 a.m. medications until 1:47 p.m. Resident 3 stated the facility was short staffed because there were days, he receives his medications several hours late and some days he will not see his nurse until noon. Resident 3 stated this makes him upset and angry. During an interview on 4/24/2025 at 3:18 p.m., with the facility pharmacist (FP), the FP stated when a resident missed a seizure medication it puts them at risk for seizures. The FP stated if a resident missed a blood pressure medication, it places them at risk for hypertension. During an interview on 4/24/2025 at 4:36 p.m., with the Director of Nursing (DON), the DON stated she was responsible for the licensed nurses ' schedules and this weekend (4/19/2025) there was a sick call and no call no show. The DON stated it was her responsibility to cover when licensed staff call off. The DON stated she should have come this past weekend (4/19/2025). The DON stated if a resident missed a blood pressure medication it could result in a stroke, if a blood thinning medication was missed it could result in a development of a blood clot, and if a seizure medication was missed it could result in the resident experiencing a seizure. During a review of the facility ' s undated P&P titled, Administering Medications, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time. During a review of the facility ' s Director of Nursing Job Description revised 10/2020, the Director of Nursing Job Description indicated the duties included, Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and treatments are provided as scheduled. Cross referenced F725

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to obtain laboratory tests per medical doctor (MD) order prior to resident scheduled appointment for one of three sampled residents (Resident 2). This deficient practice resulted in Resident 2 ' s medical doctor appointment to be canceled and had the potential delay in necessary care and services. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (a cancerous tumor) of the right breast and bone and thrombocytopenia (low blood platelet count). During a review of Resident 2 ' s Minimum Data Set (MDS- resident assessment tool) dated 3/24/2025 indicated Resident 2 ' s cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting and dressing. During an interview on 4/24/2025 at 9:49 a.m., with Resident 2, Resident 2 stated she had an appointment on Friday 4/25/2025 with her oncologist (a doctor who specializes in cancer), but her laboratory tests were not drawn. Resident 2 stated because her laboratory tests were not drawn, she had to cancel her appointment with her oncologist. Resident 2 stated this had caused her to feel frustrated. During an interview on 4/24/2025 at 10:50 a.m., with the Social Services designee (SSD), the SSD stated she was responsible for informing the Registered Nurse (RN) to set up laboratory draw appointments for the residents. The SSD stated she told the RN (unknown), that Resident 2 required laboratory tests for her upcoming appointment on 4/25/2025, but the RN had left early that day, and she did not follow up to ensure it was done. The SSD stated she will develop a system to ensure laboratory tests ordered were follow through with licensed staff as to prevent a delay in Resident 2 ' s care as SSD had to reschedule her MD appointment. During a review of the facility ' s Social Worker Job Description revised 10/2020, the Social Worker Job Description indicated the duties included, Assist in obtaining resources from community social, health, and welfare agencies to meet the needs of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055032	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Earlwood	20820 Earl Street Torrance, CA 90503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49145 Based on observation and interview, the facility failed to implement and maintain infection control practices when Certified Nurse Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 2 failed to perform hand hygiene between resident care and prior to entering and exiting resident rooms. These failures had potential of cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and placed residents and staff at risk for the spread of infection. Findings: During the initial tour of the facility on 4/25/2025, observed two of four resident rooms did not have hand sanitizing gel in the dispensers. Observed there were no hand sanitizing gel dispensers on the walls in the hallways. During a concurrent observation and interview on 4/23/2025 at 10:53 a.m., outside of resident room, LVN 2 was observed not performing hand hygiene prior to entering a resident ' s room to change an oxygen machine or prior to exiting the resident ' s room. LVN 2 stated she was supposed to perform hand hygiene before entering a resident room and prior to exiting a resident room and should have done so but forgot. LVN 2 stated hand sanitizing gel dispenser inside the resident room was empty. LVN 2 stated that not performing hand hygiene could potentially cause a spread of infection. During a concurrent observation and interview on 4/23/2025 at 11:11 a.m., with CNA 1 outside a resident room, CNA 1 was observed not performing hand hygiene prior to entering and exiting the resident room. CNA 1 stated the hand sanitizer gel dispenser was empty, but she should have gone to the nurses ' station to wash her hands. CNA 1 stated hand hygiene was important to prevent the spread of infection. During an interview on 4/23/2025 at 12:21 p.m., with the Infection Prevention Nurse (IPN), the IPN nurse stated she educates the staff on performing hand hygiene before entering a resident room, prior to leaving a resident room, and before and after resident care to prevent the transmission of infection and germs from resident to resident. IPN stated she was aware that some rooms did not have hand sanitizing gel because there was a back order on hand sanitizing gel, but the staff were educated to wash their hands at the station. IPN stated there were no hand sanitizing gel dispensers in the hallways because of the facility undergoing renovation. During an interview on 4/25/2025 at 4:36 p.m., with the Director of Nursing (DON), the DON stated hand hygiene between residents ' care was the most important way to prevent cross contamination and the spread of infection in the facility. The DON stated staff should be washing their hands before and after resident care, prior to entering and exiting a resident ' s room because not doing so can affect the safety of the residents and the staff. (continued on next page)

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	055032	A. Building B. Wing	04/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P), titled, Handwashing/Hand Hygiene, dated 9/18/2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall be trained in the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Use an alcohol-based hand rub before and after contact with the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49145 Based on interview and record review, the facility failed to have an Infection Preventionist (IP) on staff with completed specialized training in Infection Control and Prevention. This deficient practice had the potential for failure to monitor and implement Infection Control and Prevention in the facility. Findings: During a record review of the Infection Prevention Nurse (IPN) certification, dated 12/30/2024, the IPN certification indicated it was from CDC Train certificate which did not indicate the hours completed. During an interview on 4/23/2025 at 3:23 p.m., with the IPN, the IPN indicated she began working at the facility on 11/2024 as a new graduate licensed nurse and has been the IPN since 2/2025. The IPN stated the CDC Train certificate was the one she was told she needed and was unable to locate the correct Infection Preventionist certificate. During an interview on 4/24/2025 at 4:36 p.m., with the Director of Nursing (DON), the DON indicated she was unaware that the IPN had the incorrect IP certificate. The DON stated it was important to have a full-time IP nurse with the correct IP certificate for the safety of the residents and staff. The DON stated the role of IP Nurse was crucial in maintaining infection control and prevention in the facility. During a review of the facility ' s Infection Preventionist Job Description, revised 10/2020, the Infection Preventionist Job Description indicated, Plan, develop, implement, evaluate, and oversee the infection prevention and control program in accordance with current regulations and guidelines governing skilled nursing facilities. Must have, as a minimum, two years clinical experience in a hospital, nursing care facility, or other related healthcare facility.