

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor two of two sampled resident (Resident 11 and Resident 12) after a change of condition occurred.</p> <p>This failure had the potential to result in a potential delay of care to Resident 11 and Resident 12.</p> <p>Findings:</p> <p>During a review of Resident 11's admission record, the admission record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including fracture of left femur (break or injury of the thigh bone or hip) and hypertension (high blood pressure).</p> <p>During a review of Resident 11 ' s Minimum Data Set (MDS - a resident assessment tool), dated 4/23/2025, the MDS indicated Resident 11 had no cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required set-up assistance when eating, and required maximal assistance (helper does more than half the effort) with toileting and bathing.</p> <p>During a concurrent interview and record review on 5/29/2025 at 1:54 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 11 ' s medical record was reviewed. LVN 1 stated Resident 11 had an episode of emesis (vomiting), was perspiring (sweating), and was hypotensive (low blood pressure). LVN 1 stated Resident 11's blood pressure was 91/59 millimeters of mercury (mmHg- unit of measurement; normal blood pressure is 120/80) and her heart rate was 120 beats per minute (bpm - unit of measurement for heartbeat; normal heart rate is 80-100 bpm). LVN 1 stated on 4/25/2025 at 9:14 p.m., the facility informed the physician of Resident 11 ' s change of condition, and the physician recommended to continue to monitor Resident 11. LVN 1 stated the facility called 911 for the resident on 4/25/2025 at 9:16 p.m., but Resident 11 refused to transfer to the hospital at the time. LVN 1 stated Resident 11 had another episode of emesis on 4/26/2025 at 3:00 a.m., 911 was called by the facility, and Resident 11 was transferred to a general acute care hospital (GACH) on 4/26/2025 at 3:30 a.m. LVN 1 stated there is no reassessment of vital signs between 4/25/2025 9:14 p.m. and 4/26/2025 3:30 a.m. LVN 1 stated in the 6 hours, resident ' s vital signs were not reassessed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12 ' s admission record, the admission record indicated Resident 11 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and end stage renal disease (ESRD - irreversible kidney failure) with dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) .</p> <p>During a review of Resident 12 ' s MDS dated [DATE], the MDS indicated Resident 12 had no cognitive impairment, required set-up assistance when eating, and required moderate assistance (helper does less than half the effort) with toileting and bathing.</p> <p>During a concurrent interview and record review on 5/29/2025 at 1:54 p.m., with LVN 1, Resident 12 ' s medical record was reviewed. LVN 1 stated Resident 12 had a blood pressure of 79/46 mmHg on 5/28//2025 at 7:16 p.m. LVN 1 stated the facility informed the physician of Resident 112s change of condition, and the Nurse Practitioner 1 recommended to continue to recheck Resident 12 ' s blood pressure every thirty minutes three times. LVN 1 stated the facility called 911 for Resident12 on 5/29/2025 at 1:00 a.m. LVN 1 stated there was no reassessment of vital signs between 5/28//2025 at 7:16 p.m. 5/29/2025 at 1:00 a.m. LVN 1 stated in the 6 hours, resident ' s vital signs were not reassessed.</p> <p>During an interview on 5/29/2025 at 5:15 p.m., with the Director of Nursing (DON), the DON stated both Resident 11 and Resident 12 ' s vital signs should have been reassessed every 15-30 minutes even without a physician order. The DON stated it is important to reassess residents after a change of condition to know if resident ' s are improving or getting worse to get the residents proper care.</p> <p>During a review of the facility ' s policy and procedure (P&P), titled In-service Change in Condition, dated 8/25/2021, the P&P indicated the facility must consult with the resident ' s physician and/rr nurse practitioner and notify them when there l a significant change in the resident ' s physical, mental, or psychosocial status (that is a deterioration health, mental or psychosocial status in either life threatening ,conditions or clinical complications and or a decision to transfer or discharge the resident form the center/facility.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure there was a physician's order before administering oxygen to one of three sampled residents (Resident 13).</p> <p>This failure had the potential to result in a potential for hyperoxygenation (too much oxygen) Resident 13.</p> <p>Findings:</p> <p>During a review of Resident 13's admission record, the admission record indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 13 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 13 had no cognition (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, and required maximal assistance with toileting and bathing.</p> <p>During a concurrent interview and record review on 5/29/2025 at 1:54 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 13 ' s orders and oxygen monitoring were reviewed. LVN 1 stated Resident 13 uses supplemental oxygen. LVN 1 stated Resident 13 does not have an active order for oxygen administration. LVN 1 stated the order was discontinued on 4/21/2025. LVN 1 stated an order is required to administer oxygen to know how much oxygen to administer and to know what the oxygen saturation goals are. LVN 1 stated after 4/21/2025, Resident13 has 2 documented oxygen saturations (4/23/2025 and 5/23/2025).</p> <p>During an interview on 5/29/2025 at 3:15 p.m., with Resident 13 in the rehabilitation room, Resident 13 stated she wears 2 liters (L-unit of measurement) per minute (min) of oxygen every day when she needs it. Resident stated the nursing staff turn on her oxygen when she requests it.</p> <p>During an interview on 5/29/2025 at 5:15 p.m., with the Director of Nursing (DON), the DON stated all residents require a physician order for oxygen administration, including the amount of oxygen to be delivered and oxygen saturation goals, and required monitoring of oxygen saturation at least once a shift. The DON stated when a resident who has COPD is given oxygen without an order, there is a risk for hyperoxygenation.</p> <p>During a review of the facility ' s policy and procedure (P&P), titled Oxygen Administration, undated, the P&P indicated the facility is to verify that there is a physician ' s order for this procedure and review the physician ' s orders or facility protocol for oxygen administration.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nursing staff were competent in administering oxygen.</p> <p>This failure had the potential to result in a potential for hyperoxygenation (too much oxygen) Resident 13.</p> <p>Findings:</p> <p>During a review of Resident 13's admission record, the admission record indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 13 ' s Minimum Data Set (MDS &ndash; a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 13 had no cognition (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, and required maximal assistance with toileting and bathing.</p> <p>During a concurrent interview and record review on 5/29/2025 at 1:54 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 13 ' s orders and oxygen monitoring were reviewed. LVN 1 stated Resident 13 uses supplemental oxygen. LVN 1 stated Resident 13 does not have an active physician's order for oxygen administration. LVN 1 stated the order was discontinued on 4/21/2025. LVN 1 stated an order is required to administer oxygen to know how much oxygen to administer and to know what the oxygen saturation goals are. LVN 1 stated after 4/21/2025, Resident has 2 documented oxygen saturations (4/23/2025 and 5/23/2025). LVN 1 stated she not remember receiving training on oxygen administration, oxygen orders, or oxygen monitoring.</p> <p>During an interview on 5/29/2025 at 3:15 p.m. with Resident 13 in the rehabilitation room, Resident 13 stated she wears 2 liters (L-unit of measurement) per minute (min) of oxygen every day when she needs it. Resident stated the nursing staff turn on her oxygen when she requests it.</p> <p>During an interview on 5/29/2025 at 3:52 p.m. with the Director of Staff Development (DSD), the DSD stated the in-service for oxygen provided to the nursing staff does not include validating an order for oxygen, oxygen monitoring requirements, or how titrating oxygen.</p> <p>During an interview on 5/29/2025 at 5:15 p.m. with the Director of Nursing (DON), the DON stated nursing staff should be trained and in-serviced on how to administer oxygen and monitoring requirement to ensure proper use of oxygen. The DON stated when a resident who has COPD is given oxygen without an order, there is a risk for hyperoxygenation.</p> <p>During a review of the facility ' s policy and procedure (P&P), titled In-service Training, all staff, revised August 2022, the P&P indicated the primary objective of in-service training is to ensure that staff are able to interact in a manner that enhances the resident ' s quality of life and quality of care and can demonstrate competency in the topic areas of the training.</p>		