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	06/06/2025

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** Based on interview and record review the facility failed to notify one of three sampled resident's (Resident 2) physician and the facility's registered dietician (RD), when Resident 1, had a poor food intake, and refused to be weighed. These deficient practices resulted a delay in Resident 2's evaluation and care and had the potential for Resident 2 to become malnourished and lose weight. Findings: During a review of Resident 2 's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including surgical aftercare (care after surgery), malignant neoplasm (an abnormal tissue growth characterized by cells that can invade surrounding tissues and potentially spread to other parts of the body) of tongue and gastro-esophageal disease ([GERD] a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach). This action can irritate the esophagus, causing heartburn and other symptoms . During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 2 was a able to understand and be understood by others. The MDS indicated Resident 2's cognition (ability to register and recall information) was not impaired. The MDS indicated Resident 2 was diagnosed with malnutrition (body receiving inadequate nutrients) or was at risk for malnutrition. During a review of Resident 2's Nutritional Assessment, dated 2/24/2025, the Nutritional Assessment indicated Resident 2 reported she had poor appetite. The Nutritional Assessment indicated Resident 2's nutritional needs were not met; Resident 2 was consuming approximately 53% of nine meals and was not meeting greater than 75% of her nutritional needs. The Nutritional Assessment recommendation indicated Resident 2 may benefit from oral supplementation, will continue to monitor. (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
	055032	A. Building B. Wing	06/06/2025

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	During a review of Resident 2's untitled Care Plan, revised on 2/26/2025, the Care Plan indicated Resident 2 was at nutritional risk, related to a recent hospitalization and status post (after a certain event or procedure) laparoscopic cholecystectomy (surgical procedure to remove the gallbladder [organ in body] using small incisions and a small tubes to perform the surgery). The Care Plan's goals indicated Resident 2 would consume 75% of at least two-three meals every day for 30 days. The Care Plan's interventions included to weigh Resident 2 as ordered, monitor for changes in Resident 2's nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs), monitor intake at all meals, offer alternate choices as needed, and alert the dietician and physician to any decline in intake. During a review of the Resident 2's Physician's Order, the Physician's Order indicated the following: 1. On 2/20/2025 - Weigh Resident 1 every day shift each month beginning the third for one day (start on 3//3/2025) 2. On 2/20/2025 - Weigh Resident 1 every day shift each Wednesday for four weeks, (2/26/2025 through 3/26/2025). 3. On 3/3/2025 - Give Resident 2 Ensure (a food supplement) 237 milliliter ([ml] measurement of volume) with her medication pass, three times a day. During a review of Resident 2's Nursing Documentation Evaluation form, dated 2/20/2025, the Nursing Documentation form indicated Resident 2 had difficulty swallowing. During a review of Resident 2's Weights and Vitals Summary, dated 6/5/2025, the Weights and Vital Summary indicated Resident 2 reported she had a poor appetite. The Weights and Vitals Summary indicated the following: 1. On 2/21/2025 Resident 2 weighed 120 pounds (lbs.) 2. On 2/28/2025 - Resident 2 refused to be weighed, however her weight was documented as 120 lbs. 3. On 3/7/202045 - Resident 2 reused to be weighed, however her weight was documented as 120 lbs. During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2025 through 3/31/2025, the MAR indicated Resident 2 consumed the following percentage of Ensure from 3/3/2025 through 3/12/2025: 1. 100% of Ensure was consumed for eight doses 2. 75% of Ensure was consumed for 10 doses 3. 50% of Ensure was consumed for 12 doses. During a review of Resident 2's Document Survey Report, dated 3/2025. The Document Survey Report indicated Resident 2 was given 38 meals and ate 25% of the meals on two occasions, 50% of the meals on 17 occasions, 75% of the meals on six occasions, refused the meals on two occasions, there was no documentation entered on two occasions, and Resident 2 was not available/nonapplicable on three occasions. (continued on next page)

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	06/06/2025

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	During an interview on 6/5/2025 at 3:11.p.m., the Registered Dietician (RD) stated when she conducted Resident 2's nutritional admission assessment on 2/24/2025, Resident 2 informed her that she her appetite was poor, and her plan was to reassess Resident 2 if there was a decline in her weight and meal consumption. The RD stated Resident 2's had a physician's order, dated 2/20/2025 for a ST evaluation and at the time of her assessment on 2/24/2025, she (RD) determined Resident 2's diet was regular and would wait on the ST's evaluation of Resident 2 for further determination of her nutritional status. The RD stated after reviewing Resident 2's clinical record the ST never evaluated Resident 2. She (RD) also noted that Resident 2's last documented weight was 120 lbs. on 2/21/2025 and although Resident 2 refused to be weighed on 2/28/2025 and 3/7/20205 a weight of 120 lbs. was entered for both of those days, which gives an incorrect status of Resident 2's weight/nutritional status. The RD says no one notified her that Resident 2 refused to be weighed on 2/28/2025 and 3/7/2025 or that Resident 2's meal consumption was poor several days. The RD stated had the information been communicated to her, she would have reassessed Resident 2 and revised her nutritional care plan. The RD stated the lack of communication regarding Resident 2's poor food intake, and refusal to be weighed caused a delay her evaluation and care. During an interview on 6/6/2024 at 4:30 p.m., the Director of Nursing (DON), after reviewing Resident 2's clinical record, stated Resident 2's was at risk for malnutrition and should have been monitored closely for weight loss and a decline food intake. The DON stated the nursing staff should have notified the RD and Resident 2's physician for any changes in Resident 2's nutritional status. The DON stated failure to notify the RD and Resident 's 2 physician led to Resident 2 experiencing a delay in evaluation and care. During a review of the facility's P/P, titled, Care Plan Comprehensive, dated 8/25/2021, the P/P indicated the facility's interdisciplinary team, in coordination with the resident and or her family, or representative, must develop and implement a comprehensive person centered plan of care for each resident. 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 the purpose of the policy is ensure residents, family and legal representatives and physicians are informed of changes in the resident's condition. The facility must immediately notify the resident, consult with the resident's physician and or NP and notify consistent with his/her authority, the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review the facility failed to notify one of three sampled resident's (Resident 2) physician and the facility's registered dietician (RD), when Resident 1, had a poor food intake, and refused to be weighed. These deficient practices resulted a delay in Resident 2's evaluation and care and had the potential for Resident 2 to become malnourished and lose weight. Findings: (continued on next page)

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	06/06/2025

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	During a review of Resident 2 's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including surgical aftercare (care after surgery), malignant neoplasm (an abnormal tissue growth characterized by cells that can invade surrounding tissues and potentially spread to other parts of the body) of tongue and gastro-esophageal disease ([GERD] a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach). This action can irritate the esophagus, causing heartburn and other symptoms . During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 2 was a able to understand and be understood by others. The MDS indicated Resident 2's cognition (ability to register and recall information) was not impaired. The MDS indicated Resident 2 was diagnosed with malnutrition (body receiving inadequate nutrients) or was at risk for malnutrition. During a review of Resident 2's Nutritional Assessment, dated 2/24/2025, the Nutritional Assessment indicated Resident 2 reported she had poor appetite. The Nutritional Assessment indicated Resident 2's nutritional needs were not met; Resident 2 was consuming approximately 53% of nine meals and was not meeting greater than 75% of her nutritional needs. The Nutritional Assessment recommendation indicated Resident 2 may benefit from oral supplementation, will continue to monitor. During a review of Resident 2's untitled Care Plan, revised on 2/26/2025, the Care Plan indicated Resident 2 was at nutritional risk, related to a recent hospitalization and status post (after a certain event or procedure) laparoscopic cholecystectomy (surgical procedure to remove the gallbladder [organ in body] using small incisions and a small tubes to perform the surgery). The Care Plan's goals indicated Resident 2 would consume 75% of at least two-three meals every day for 30 days. The Care Plan's interventions included to weigh Resident 2 as ordered, monitor for changes in Resident 2's nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs), monitor intake at all meals, offer alternate choices as needed, and alert the dietician and physician to any decline in intake. During a review of the Resident 2's Physician's Order, the Physician's Order indicated the following: 1. On 2/20/2025 - Weigh Resident 1 every day shift each month beginning the third for one day (start on 3//3/2025) 2. On 2/20/2025 - Weigh Resident 1 every day shift each Wednesday for four weeks, (2/26/2025 through 3/26/2025). 3. On 3/3/2025 - Give Resident 2 Ensure (a food supplement) 237 milliliter ([ml] measurement of volume) with her medication pass, three times a day. During a review of Resident 2's Nursing Documentation Evaluation form, dated 2/20/2025, the Nursing Documentation form indicated Resident 2 had difficulty swallowing. During a review of Resident 2's Weights and Vitals Summary, dated 6/5/2025, the Weights and Vital Summary indicated Resident 2 reported she had a poor appetite. The Weights and Vitals Summary indicated the following: (continued on next page)

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	06/06/2025

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	1. On 2/21/2025 Resident 2 weighed 120 pounds (lbs.) 2. On 2/28/2025 - Resident 2 refused to be weighed, however her weight was documented as 120 lbs. 3. On 3/7/202045 - Resident 2 reused to be weighed, however her weight was documented as 120 lbs. During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2025 through 3/31/2025, the MAR indicated Resident 2 consumed the following percentage of Ensure from 3/3/2025 through 3/12/2025: 1. 100% of Ensure was consumed for eight doses 2. 75% of Ensure was consumed for 10 doses 3. 50% of Ensure was consumed for 12 doses. During a review of Resident 2's Document Survey Report, dated 3/2025. The Document Survey Report indicated Resident 2 was given 38 meals and ate 25% of the meals on two occasions, 50% of the meals on 17 occasions, 75% of the meals on six occasions, refused the meals on two occasions, there was no documentation entered on two occasions, and Resident 2 was not available/nonapplicable on three occasions. During an interview on 6/5/2025 at 3:11.p.m., the Registered Dietician (RD) stated when she conducted Resident 2's nutritional admission assessment on 2/24/2025, Resident 2 informed her that she her appetite was poor, and her plan was to reassess Resident 2 if there was a decline in her weight and meal consumption. The RD stated Resident 2's had a physician's order, dated 2/20/2025 for a ST evaluation and at the time of her assessment on 2/24/2025, she (RD) determined Resident 2's diet was regular and would wait on the ST's evaluation of Resident 2 for further determination of her nutritional status. The RD stated after reviewing Resident 2's clinical record the ST never evaluated Resident 2. She (RD) also noted that Resident 2's last documented weight was 120 lbs. on 2/21/2025 and although Resident 2 refused to be weighed on 2/28/2025 and 3/7/20205 a weight of 120 lbs. was entered for both of those days, which gives an incorrect status of Resident 2's weight/nutritional status. The RD says no one notified her that Resident 2 refused to be weighed on 2/28/2025 and 3/7/2025 or that Resident 2's meal consumption was poor several days. The RD stated had the information been communicated to her, she would have reassessed Resident 2 and revised her nutritional care plan. The RD stated the lack of communication regarding Resident 2's poor food intake, and refusal to be weighed caused a delay her evaluation and care. During an interview on 6/6/2024 at 4:30 p.m., the Director of Nursing (DON), after reviewing Resident 2's clinical record, stated Resident 2's was at risk for malnutrition and should have been monitored closely for weight loss and a decline food intake. The DON stated the nursing staff should have notified the RD and Resident 2's physician for any changes in Resident 2's nutritional status. The DON stated failure to notify the RD and Resident 's 2 physician led to Resident 2 experiencing a delay in evaluation and care. During a review of the facility's P/P, titled, Care Plan Comprehensive, dated 8/25/2021, the P/P indicated the facility's interdisciplinary team, in coordination with the resident and or her family, or representative, must develop and implement a comprehensive person centered plan of care for each resident. (continued on next page)

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	06/06/2025

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	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 the purpose of the policy is ensure residents, family and legal representatives and physicians are informed of changes in the resident's condition. The facility must immediately notify the resident, consult with the resident's physician and or NP and notify consistent with his/her authority, the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment.

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	06/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a history of elopement (act of leaving a facility unsupervised and without prior authorization) and wandering (moving from place to place) behaviors did not elope from the facility. This deficient practice resulted in Resident 1 eloping from the facility on 6/5/2025 at approximately 5:32 p.m., unbeknownst to staff. Resident 1 was returned to the facility on the same day after being found by a Good Samaritan at approximately 5:55 p.m. This deficient practice place Resident 1 at risk for harm as a result of in climate weather, motor vehicle accidents, fall, violence at the hands of others and death. This deficient practice resulted in Resident 1 eloping from the facility and placed Resident 1 at risk for the potential excessive changes in temperature, motor vehicle accidents, falls, violence and death. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremors, muscle rigidity and slow, imprecise movements), dementia (a progressive state of decline in mental abilities) and muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was moderately impaired. During a review of Resident 1's Nursing Documentation Evaluation form, dated 5/25/2025, the Nursing Documentation Evaluation form indicated Resident 1 was alert and confused and had wandering (traveling aimlessly from place to place) behaviors. During a review of Resident 1's untitled Care Plan, revised on 5/27/2025, the Care Plan indicated Resident 1 was at risk for wandering/elopement (the act of leaving a facility unsupervised and without prior authorization). The Care Plan's goal indicated Resident 1 would not leave facility unattended and his safety would be maintained. The Care Plan's interventions included engaging Resident 1 in purposeful activity, identifying any triggers for wandering/eloping, identifying certain times of the day that wander/elopement attempts occur, identifying patterns and purpose of wandering, implementing wander/elopement de-escalation behaviors, and Resident 1 should be in a common area or attend activities of choice for close monitoring. During a review of Resident 1's Change of Condition (COC) Evaluation, dated 5/27/2025, the COC Evaluation indicated Resident 1 was noted to have at risk for elopement due to wandering behavior (unsure what the behavior was). The COC Evaluation indicated Resident 1's physician was notified on 5/27/2025 at 12:20 p.m. and a wander guard (a bracelet worn by residents at risk for wandering/elopement that alerts caregivers when residents approach a monitored door by triggering an alarm) bracelet was ordered to be applied. (continued on next page)

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	06/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Order Summary Report (Physician's Order) dated 5/27/2025, the Physician's Order indicated a wander guard for Resident 1 and to check for placement for wander guard to left wrist every shift. During a review of Resident 1's COC Evaluation, dated 6/5/2025, the COC Evaluation indicated Resident 1 was served dinner at approximately 5.25 p.m., on 6/5/2025, and at approximately 5:32 p.m., Certified Nurse Assistant (CNA) 1, noticed Resident 1 was not in his room and she (CNA 1) alerted Licensed Vocational Nurse (LVN) 1. The COC Evaluation indicated staff searched throughout the building, the surrounding premises and streets by foot and car. The COC Evaluation indicated Resident 1 was found by a Good Samaraitan at approximately 5:50 p.m., (6/5/2025), the Good Samaritan called the Fire Department who contacted the facility. The COC Evaluation indicated the Administrator (ADM) picked Resident 1 up and returned Resident 1 to the facility at 6:20 p.m., on 6/5/2025. During a review of the facility's Unusual Occurrence letter, dated 6/6/2025, the Unusual Occurrence letter indicated on 6/5/2025 at approximately 5.25 pm., Resident 1 was served dinner in the hallway and at 5:32 p. m., Resident 1 was not in the hallway eating dinner. The Unusual Occurrence letter indicated facility staff immediately initiated a search of the facility premises and nearby areas. The Unusual Occurrence letter indicated at approximately 5:55 p.m., the facility received a call from the local police department reporting that Resident 1 had been located. The Unusual Occurrence letter indicated the ADM drove to Resident 1's location picked him up and returned him to the facility. During an interview on 6/6/2025 at 11:40 a.m., Resident 1 stated he walked out of the facility's door, but he did not remember which door. Resident 1 stated he left because he wanted to leave. During an interview on 6/6/2025 at 3:08 p.m., CNA 1 stated at approximately 5:20 p.m., on 6/5/2025, she (CNA 1) directed Resident 1 to sit in his wheelchair in the hallway, to eat dinner while she passed dinner trays to other residents. CNA 1 stated she did not have visual confirmation of Resident 1's location while she passed dinner trays, nor did she inform other staff members that she would be unable to maintain a direct line of sight of Resident 1's whereabouts. CNA 1 stated at approximately 5:35 pm., she did not see Resident 1 in his wheelchair and immediately notified LVN 1 along with other staff members to search for Resident 1. CNA 1 did not hear a wander guard alarm alerting her that Resident 1 had left the building. During an interview on 6/6/2025 at 3:26 p.m., the Director of Staff Development (DSD) stated on 6/5/2025 at approximately 5:50 p.m., she and the ADM received a phone call from the police that Resident 1 had been located on the street about a four minute drive from the facility. During an interview on 6/6/2025, at 4:30 p.m., the DON stated a wander guard bracelet is worn by residents, who are at risk for elopement, but it does not prevent a resident from eloping, it is only a monitoring system. The DON stated it is the responsibility of the facility staff to supervise, monitor and redirect residents to prevent them from eloping. The DON stated Resident 1 eloping from the facility placed him at risk for injury from falls, car accidents or violence. During an interview on 6/6/2025, at 4:40 p.m., the ADM stated the wander guard was a reactive monitoring system that enhanced interventions that staff should have been providing such as monitoring Resident 1. (continued on next page)

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	06/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Product Document for the wander guard, titled System Installment Guide for Code Alert dated 12/2017, the Product Document indicated the most reliable method of resident monitoring combines close personal surveillance with correct operation of monitoring equipment. During a review of the facility's Policy and Procedure (P&P) titled, Elopements revised 2/21/2025, the P&P indicated residents who exhibit wandering behavior and/or were at risk for elopement, receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a history of elopement (act of leaving a facility unsupervised and without prior authorization) and wandering (moving from place to place) behaviors did not elope from the facility. This deficient practice resulted in Resident 1 eloping from the facility on 6/5/2025 at approximately 5:32 p.m., unbeknownst to staff. Resident 1 was returned to the facility on the same day after being found by a Good Samaritan at approximately 5:55 p.m. This deficient practice place Resident 1 at risk for harm as a result of in climate weather, motor vehicle accidents, fall, violence at the hands of others and death. This deficient practice resulted in Resident 1 eloping from the facility and placed Resident 1 at risk for the potential excessive changes in temperature, motor vehicle accidents, falls, violence and death. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremors, muscle rigidity and slow, imprecise movements), dementia (a progressive state of decline in mental abilities) and muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was moderately impaired. During a review of Resident 1's Nursing Documentation Evaluation form, dated 5/25/2025, the Nursing Documentation Evaluation form indicated Resident 1 was alert and confused and had wandering (traveling aimlessly from place to place) behaviors. During a review of Resident 1's untitled Care Plan, revised on 5/27/2025, the Care Plan indicated Resident 1 was at risk for wandering/elopement (the act of leaving a facility unsupervised and without prior authorization). The Care Plan's goal indicated Resident 1 would not leave facility unattended and his safety would be maintained. The Care Plan's interventions included engaging Resident 1 in purposeful activity, identifying any triggers for wandering/eloping, identifying certain times of the day that wander/elopement attempts occur, identifying patterns and purpose of wandering, implementing wander/elopement de-escalation behaviors, and Resident 1 should be in a common area or attend activities of choice for close monitoring. (continued on next page)

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	06/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change of Condition (COC) Evaluation, dated 5/27/2025, the COC Evaluation indicated Resident 1 was noted to have at risk for elopement due to wandering behavior (unsure what the behavior was). The COC Evaluation indicated Resident 1's physician was notified on 5/27/2025 at 12:20 p.m. and a wander guard (a bracelet worn by residents at risk for wandering/elopement that alerts caregivers when residents approach a monitored door by triggering an alarm) bracelet was ordered to be applied. During a review of Resident 1's Order Summary Report (Physician's Order) dated 5/27/2025, the Physician's Order indicated a wander guard for Resident 1 and to check for placement for wander guard to left wrist every shift. During a review of Resident 1's COC Evaluation, dated 6/5/2025, the COC Evaluation indicated Resident 1 was served dinner at approximately 5.25 p.m., on 6/5/2025, and at approximately 5:32 p.m., Certified Nurse Assistant (CNA) 1, noticed Resident 1 was not in his room and she (CNA 1) alerted Licensed Vocational Nurse (LVN) 1. The COC Evaluation indicated staff searched throughout the building, the surrounding premises and streets by foot and car. The COC Evaluation indicated Resident 1 was found by a Good Samaraitan at approximately 5:50 p.m., (6/5/2025), the Good Samaritan called the Fire Department who contacted the facility. The COC Evaluation indicated the Administrator (ADM) picked Resident 1 up and returned Resident 1 to the facility at 6:20 p.m., on 6/5/2025. During a review of the facility's Unusual Occurrence letter, dated 6/6/2025, the Unusual Occurrence letter indicated on 6/5/2025 at approximately 5.25 pm., Resident 1 was served dinner in the hallway and at 5:32 p. m., Resident 1 was not in the hallway eating dinner. The Unusual Occurrence letter indicated facility staff immediately initiated a search of the facility premises and nearby areas. The Unusual Occurrence letter indicated at approximately 5:55 p.m., the facility received a call from the local police department reporting that Resident 1 had been located. The Unusual Occurrence letter indicated the ADM drove to Resident 1's location picked him up and returned him to the facility. During an interview on 6/6/2025 at 11:40 a.m., Resident 1 stated he walked out of the facility's door, but he did not remember which door. Resident 1 stated he left because he wanted to leave. During an interview on 6/6/2025 at 3:08 p.m., CNA 1 stated at approximately 5:20 p.m., on 6/5/2025, she (CNA 1) directed Resident 1 to sit in his wheelchair in the hallway, to eat dinner while she passed dinner trays to other residents. CNA 1 stated she did not have visual confirmation of Resident 1's location while she passed dinner trays, nor did she inform other staff members that she would be unable to maintain a direct line of sight of Resident 1's whereabouts. CNA 1 stated at approximately 5:35 pm., she did not see Resident 1 in his wheelchair and immediately notified LVN 1 along with other staff members to search for Resident 1. CNA 1 did not hear a wander guard alarm alerting her that Resident 1 had left the building. During an interview on 6/6/2025 at 3:26 p.m., the Director of Staff Development (DSD) stated on 6/5/2025 at approximately 5:50 p.m., she and the ADM received a phone call from the police that Resident 1 had been located on the street about a four minute drive from the facility. (continued on next page)

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	06/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025, at 4:30 p.m., the DON stated a wander guard bracelet is worn by residents, who are at risk for elopement, but it does not prevent a resident from eloping, it is only a monitoring system. The DON stated it is the responsibility of the facility staff to supervise, monitor and redirect residents to prevent them from eloping. The DON stated Resident 1 eloping from the facility placed him at risk for injury from falls, car accidents or violence. During an interview on 6/6/2025, at 4:40 p.m., the ADM stated the wander guard was a reactive monitoring system that enhanced interventions that staff should have been providing such as monitoring Resident 1. During a review of the facility's Product Document for the wander guard, titled System Installment Guide for Code Alert dated 12/2017, the Product Document indicated the most reliable method of resident monitoring combines close personal surveillance with correct operation of monitoring equipment. During a review of the facility's Policy and Procedure (P&P) titled, Elopements revised 2/21/2025, the P&P indicated residents who exhibit wandering behavior and/or were at risk for elopement, receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the weights and food consumption for one of three sampled residents (Resident 2) was obtained and/or assessed. These deficient practices resulted in Resident 2's weights and food consumption being unknown and a delay in evaluation and care. These deficient practices placed Resident 2 at risk for malnutrition and weight loss. Findings: During a review of Resident 2 's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including surgical aftercare (care after surgery), malignant neoplasm (an abnormal tissue growth characterized by cells that can invade surrounding tissues and potentially spread to other parts of the body) of tongue and gastro-esophageal disease ([GERD] a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach). This action can irritate the esophagus, causing heartburn and other symptoms . During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 2 was a able to understand and be understood by others. The MDS indicated Resident 2's cognition (ability to register and recall information) was not impaired. The MDS indicated Resident 2 was diagnosed with malnutrition (body receiving inadequate nutrients) or was at risk for malnutrition. During a review of the Resident 2's Order Summary Report (Physician's Order), dated 2/20/2025, the Physician's Order indicated the following: 1. On 2/20/2025 - Weigh Resident 1 every day shift each month beginning the third for one day (start on 3//3/2025) 2. On 2/20/2025 - Weigh Resident 1 every day shift each Wednesday for four weeks, (2/26/2025 through 3/26/2025). 3. On 3/3/2025 - Give Resident 2 Ensure (a food supplement) 237 milliliter ([ml] measurement of volume) with her medication pass, three times a day. During a review of Resident 2's Nursing Documentation Evaluation form, dated 2/20/2025, the Nursing Documentation form indicated Resident 2 had difficulty swallowing. During a review of Resident 2's Nutritional Assessment, dated 2/24/2025, the Nutritional Assessment indicated Resident 2 reported she had poor appetite. The assessment further indicated Resident 2's nutritional needs are not met; Resident 2 is consuming about 53% of nine meals and not meeting greater than 75% of nutritional needs. The assessment recommendation indicated the following, Resident 2 confirms poor appetite, may benefit from oral supplementation to better nutritional needs, will continue to monitor. (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Weights and Vitals Summary, dated 6/5/2025, the Weights and Vital Summary indicated Resident 2 reported she had a poor appetite. The Weights and Vitals Summary indicated the following: 1. On 2/21/2025 Resident 2 weighed 120 pounds (lbs.) 2. On 2/28/2025 - Resident 2 refused to be weighed, however her weight was documented as 120 lbs. 3. On 3/7/202045 - Resident 2 reused to be weighed, however her weight was documented as 120 lbs. During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2025 through 3/31/2025, the MAR indicated Resident 2 consumed the following percentage of Ensure from 3/3/2025 through 3/12/2025: 1. 100% of Ensure was consumed for eight doses 2. 75% of Ensure was consumed for 10 doses 3. 50% of Ensure was consumed for 12 doses. During a review of Resident 2's Document Survey Report, dated 3/2025. The Document Survey Report indicated Resident 2 was given 38 meals and ate 25% of the meals on two occasions, 50% of the meals on 17 occasions, 75% of the meals on six occasions, refused the meals on two occasions, there was no documentation entered on two occasions, and Resident 2 was not available/nonapplicable on three occasions. During a review of Resident 2's untitled Care Plan, revised on 2/26/2025, the Care Plan indicated Resident 2 was at nutritional risk, related to a recent hospitalization and status post (after a certain event or procedure) laparoscopic cholecystectomy (surgical procedure to remove the gallbladder [organ in body] using small incisions and a small tubes to perform the surgery). The Care Plan's goals indicated Resident 2 would consume 75% of at least two-three meals every day for 30 days. The Care Plan's interventions included to weigh Resident 2 as ordered, monitor for changes in Resident 2's nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs), monitor intake at all meals, offer alternate choices as needed, and alert the dietician and physician to any decline in intake. During an interview on 6/5/2025 at 10 a.m., Resident 2 stated she did not receive adequate nutrition during her stay at the facility and she lost so much weight her dentures became lose. Resident 2 stated she was given bread and which she could not chew. Resident 2 stated because of a surgery she'd had on her tongue due to cancer, she had difficulty chewing and swallowing. Resident 2 stated she was never evaluated for the appropriate diet and when she requested a different diet than the one she was given, she did not receive it. Resident 2 stated she felt weak and unhealthy because she was receiving an inappropriate diet (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 11 a.m., the Registered Dietician (RD) stated she conducted Resident 2's nutritional admission assessment on 2/24/2025 and was told by Resident 2 that she (Resident 2) had a poor appetite, and her plan was to reassess Resident 2 if there was a decline in her weight and meal consumption. The RD stated Resident 2's had a physician's order, dated 2/20/2025 for a ST evaluation and at the time of her assessment on 2/24/2025, she (RD) determined Resident 2's diet was regular and would wait on the ST's evaluation of Resident 2 for further determination of her nutritional status. The RD stated after reviewing Resident 2's clinical record the ST never evaluated Resident 2. She (RD) also noted that Resident 2's last documented weight was 120 lbs. on 2/21/2025 and although Resident 2 refused to be weighed on 2/28/2025 and 3/7/20205 a weight of 120 lbs. was entered for both of those days, which gives an incorrect status of Resident 2's weight/nutritional status. The RD says no one notified her that Resident 2 refused to be weighed on 2/28/2025 and 3/7/2025 or that Resident 2's meal consumption was poor several days. The RD stated had the information been communicated to her, she would have reassessed Resident 2 and revised her nutritional care plan. The RD stated the lack of communication regarding Resident 2's poor food intake, and refusal to be weighed caused a delay her evaluation and care. During an interview on 6/5/2025 at 4:45 p.m., Resident 2's Responsible Party (RP 2) stated she and Resident 2 frequently asked for a different diet because Resident 2 had a difficult time chewing and eating the food the facility provided. RP 2 stated their requests were never met and there was no communication from the facility staff regarding Resident 2's nutrition goal. During an interview on 6/6/2024 at 4:30 p.m., the Director of Nursing (DON), after reviewing Resident 2's clinical record, stated Resident 2's was at risk for malnutrition and should have been monitored closely for weight loss and a decline food intake. The DON stated the nursing staff should have notified the RD and Resident 2's physician for any changes in Resident 2's nutritional status. The DON stated failure to notify the RD and Resident 's 2 physician led to Resident 2 experiencing a delay in evaluation and care. During a review of the facility's undated Policy and Procedure (P/P), titled, Weight Management the P/P indicated it is the policy of the facility to obtain baseline weight and identify significant weight change; weighs will be obtained weekly for four weeks after admission. During a review of the facility's P/P, titled, Care Plan Comprehensive, dated 8/25/2021, the P/P indicated the facility's interdisciplinary team, in coordination with the resident and or her family, or representative, must develop and implement a comprehensive person centered plan of care for each resident. During a review of the facility's undated P/P, titled, Requesting, Refusing and or Discontinuing Care or Treatment, the P/P indicated if a resident/representative requests, discontinues or refuses care or treatment, an appropriate member of the IDT will meet with the resident/representative to determine why she is requesting, refusing or discontinuing care or treatment, try to address her concerns and discuss alternative options, and discuss the potential outcomes or consequences (positive and negative) of that decision. Based on interview and record review the facility failed to accurately and consistently assess one of three sampled resident's (Resident 2) nutritional status (state of a person's health in terms of the nutrients in her diet) (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after admission. The facility failed to 1.notify the Registered Dietician(RD) and Resident 2's physician of Resident 2's decline in meal and Ensure (meal supplement for residents at nutritional risk, experiencing involuntary weight loss, recovering from illness or surgery) consumption . 2. Failed to accurately document Resident 2's weight, when Resident 2 refused to be weighed on 2/28/2025 and 3/7/2025. 3. Failed to implement a physician order for Speech Therapist (health professionals who evaluate, diagnose, and treat individuals with swallowing disorders) evaluation. 4. Conduct an interdisciplinary team (IDT-group of healthcare professional who work with the Resident and or Resident representative to care a plan of care with goals and interventions) to address Resident 2's risk for malnutrition. These deficient practices resulted in an 1.Lack of weights leading to inaccurate clinical assessment of Resident 2 ' s nutritional status status placing Resident 2 at further risk for malnutrition (body receiving less nutrients). 2. Lack of appropriate Speech Therapy Evaluation to determine the proper diet for Resident 2. 3. Resident 2's feeling frustrated at not being involved in her plan of care. 4. Resident 2 stating she felt unwell and malnourished due to being unable to chew and swallow her food which was determined to be a Regular diet (consisting of foods of various textures, may be hard and crunchy or naturally soft) assessed once , upon Resident 2 ' s admission. Findings: During a review of Resident 2 's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including surgical aftercare (care after surgery), malignant neoplasm (abnormal tissue growth characterized by cells that can invade surrounding tissues and potentially spread to other parts of the body) of tongue and gastro-esophageal (affecting stomach and esophagus [muscular tube connecting throat to stomach) disease. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 2 was always able to understand and be understood by others. The MDS indicated Resident 2's cognition (ability to register and recall information) was not impaired. The MDS indicated Resident 2 had an active diagnosis of malnutrition or at risk for malnutrition and underwent a major surgical procedure prior to her admission to the facility. During a review of the Resident 2's Order Summary Report, indicated on 2/20/2025, Speech Therapy (ST), Evaluation and Treatment as recommended. (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Resident 2's Order Summary Report, indicated the following orders placed on 2/20/2025 : weigh for risk of malnutrition every day shift every month starting on the third for one day (start on 3/3/2025) ; weigh for risk of malnutrition every day shift every Wednesday for four weeks, (2/26/2025 through 3/26/2025). During a review of the Resident 2's Order Summary Report, to start on indicated on 3/3/2025, Administer Ensure 237 milliliter (ml- measurement of volume) ls with med pass, three times a day. During a review of Resident 2's Nursing Documentation Evaluation form , dated 2/20/2025, the form indicated Resident 2 had difficulty swallowing. During a review of Resident 2's nutritional assessment, dated 2/24/2025, the assessment indicated Resident 2 reported she had poor appetite. The assessment further indicated Resident 2's nutritional needs are not met; Resident 2 is consuming about 53% of nine meals and not meeting greater than 75% of nutritional needs. The assessment recommendation indicated the following, Resident 2 confirms poor appetite, may benefit from oral supplementation to better nutritional needs, will continue to monitor. During a review of Resident 2's weights and vitals summary, dated 6/5/2025, the summary indicated Resident 2 reported she had poor appetite. The assessment further indicated the following weight values for Resident 2: on 2/21/2025 at 5:42 p.m., weight :120 pounds (lbs-unit of measurement), on 2/28/2025 at 9:20 p. m. weight : 120lbs , last weight obtained, Resident 2 refused; on 3/7/2025 at 5:03 p.m., weight : 120 lbs last weight obtained, Resident 2 refused. During a review of Resident 2's Medication Administration Record (MAR) dated 3/1/2025 through 3/31/2025, the MAR indicated the following: Administer Ensure 237 mls with med pass starting on 3/3/2025 at 9am. The MAR indicated the following consumption percentages from 3/3/2025 through 3/12/2025. The MAR indicated the following consumption percentages, 100 % x 8 doses; 75% x 10 doses, and 50% x 12 doses. During a review of Resident 2's document survey report , dated 3/2025. The report indicated Resident 2 had 38 meal opportunities. The report indicated the following of 38 meals , Resident 2 consumed 25% of meals on 2 occasions, 50% of meals on 17 occasions, 75% of meals on six occasions, refused meals on two occasions, no documentations was entered on two occasions, resident was not available/ nonapplicable on three occasions. During a review of the Resident 2's Care Plan, revised on 2/26/2025, the Care Plan indicated Resident 2 was at nutritional risk, recent hospitalization, status post laparoscopic cholecystectomy. The Care Plan's goals indicated Resident 2 will consume 75% of at least 2-3 meals every day for 30 days, target date on 5/22/2025. The Care Plan's interventions included weigh as ordered, monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/ physician as indicated, monitor intake at all meals, offer alternate choices as needed, alert dietician and physician to any decline in intake. (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 10 a.m., Resident 2 stated she had lost weight during her stay at the facility and did not receive adequate nutrition. Resident 2 stated she lost so much weight that her dentures became lose due to her receiving an inappropriate diet. Resident 2 stated I was receiving bread which I couldn't chew. Resident 2 stated she previous had tongue cancer which make it difficult for her to chew and swallow. Resident 2 stated she asked for a different diet, but the request was unmet. Resident 2 stated she was never evaluated for the appropriate diet. Resident 2 stated the lack of nutrition caused her to feel weak and unhealthy. During an interview on 6/5/2025 at 11 a.m., the Registered Dietician (RD) stated when she conducted Resident 2's nutritional admission assessment on 2/24/2025, she (RD) noted Resident 2 informed her (RD) that she (Resident 2) had poor appetite. RD stated she planned to reassess Resident 2 if there was a decline in Resident 2's weight and meal consumption. RD stated based on her review of Resident 2's clinical records, Resident 2 had a physician order, dated 2/20/2025 for speech therapy evaluation. RD stated at the time of her assessment on 2/24/2025, RD determined Resident 2's diet to be regular until further determination by speech therapy. RD stated based on her review of Resident 2's clinical records, speech therapy did not assess Resident 2. RD stated based on further review, Resident 2's weight entered on 2/21/2025 was 120 pounds. RD stated although the clinical records indicate on 2/28/2025 and 3/7/2025 Resident 2 refused weight assessments, 120 pounds was entered which resulted in an inaccurate picture of Resident 2's nutritional status. RD stated she was not notified by the nursing staff of Resident 2's refusal to be weighed nor that Resident 2's meal and Ensure consumption was under 100%. RD stated had the information been communicated to her, she would have reassessed Resident 2 and revised Resident 2's nutritional care plans. RD stated she was not aware of an IDT meeting held to discuss Resident 2's nutritional status/goals. RD stated Resident 2's pre-albumin was 7mg/dL (range 18-38), collected on 2/24/2025, which considering Resident 2's clinical picture, could be an indication of malnutrition. RD stated there could have been better communication with the bedside staff and IDT regarding Resident ' s refusal of weights, decline in meal consumption and lack of speech therapy follow up. RD stated due to the lack of communication, there was a delay in ensuring Resident 2 received individualized, appropriate nutrition to support her (Resident 2's) overall health. During an interview on 6/5/2025 at 4:45 p.m., Resident 2's Responsible Party (RP 2) stated she and Resident 2 frequently asked for a different diet because Resident 2 had a difficult time chewing and consuming the food the facility had provided. RP 2 stated their requests were never met and they did not receive any communication from the facility staff regarding Resident 2's nutrition goal including being involved in Resident 2's plan of care. During an interview on 6/6/2025 at 12 p.m., the Minimum Data Set (MDS), stated Resident 2 should have had an IDT shortly after her admission to discuss nutritional goals including the importance of weekly weights, meal and supplement consumption tracking and speech therapy evaluation. MDS stated based on her review of Resident 2's clinical records, Resident 2 did not have an IDT focused on her nutritional goals, nor were there documentation indicating why Resident 2 weights were refused, no documentation indicating the licensed nurse was aware that Resident 2 had a pattern of consuming 75% of meals and supplements. The MDS nurse stated there was no documenting the above issues were addressed with Resident 2 or Resident 2's responsible party. (continued on next page)

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	06/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/2025 at 2 p.m., the Director of Rehabilitation (DOR), stated Resident 2 had a physician's order for speech therapy evaluation which was not carried out. The DOR stated she was not sure why it was overlooked by the rehabilitation department. The DOR stated speech therapy would be important in determining Resident 2's appropriate diets especially due to Resident 1's decreased consumption. The DOR stated Resident 2 should have had an IDT to discuss nutritional status. During an interview on 6/6/2024 at 4:30 p.m., the DON stated based on his review of Resident 2's clinical records, Resident 2 was at risk for malnutrition and should have been monitored closely for weight loss and a decline intake. The DON stated there should have been an IDT meeting to discuss Resident 2's nutritional goals which included a Speech Therapy evaluation. The DON stated, Resident 2 experienced a delay in assessments and services leading possible malnutrition. During a review of the facility's undated Policy and Procedure (P/P), titled, Weight Management the P/P indicated it is the policy of the facility to obtain baseline weight and identify significant weight change; weighs will be obtained weekly for four weeks after admission. During a review of the facility's P/P, titled, Care plan comprehensive, dated 8/25/2021, the P/P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical , mental and psychological needs shall be developed for each resident. The P/P further indicated , the facility's interdisciplinary team, in coordination with the resident and or her family, or representative, must develop and implement a comprehensive person centered plan of care for each resident that includes measurable objectives and timeframes to meet a resident's medical, physical and mental and psychosocial needs that are identified in the comprehensive care plan. During a review of the facility's undated P/P, titled, Requesting, Refusing and or Discontinuing Care or Treatment , the P/P indicated if a resident/ representative requests, discontinues or refuses care or treatment, an appropriate member of the IDT will meet with the resident/representative to determine why she is requesting, refusing or discontinuing care or treatment, try to address her concerns and discuss alternative options, and discuss the potential outcomes or consequences (positive and negative) of that decision.

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	06/06/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to ensure their QA/QAPI (Quality Assurance/Quality Assurance and Performance Improvement, a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee monitored interventions put in place related to delays in receiving resident care. This deficient practices resulted in the inability of the facility to determine if interventions put in place to improve resident care in a timely manner were affective and placed residents at risk for continued delay in care and services. Findings: During a review of the facility's Grievance Report dated 5/16/2024, the Grievance Report indicated Resident 4 had concerns related to answering of call lights (device used by resident to ask for assistance) in a timely manner. The Grievance Report indicated the facility will continue to address the concern during their QAPI meeting. During a review of the facility's Grievance Report dated 4/15/2025, the Grievance Report indicated Resident 4 had concerns related to resident care, call lights and customer service. The Grievance Report indicated actions taken to resolve the concern was to provide in-service staff on answering call lights in a timely manner. During a review of the facility's Grievance Report dated 5/19/2025, the Grievance Report indicated Resident 5 did not receive resident care in a timely manner. The Grievance Report indicated actions taken to resolve the concern was for the Director of Nursing (DON) to provide in-services to staff on answering call lights in a timely manner. During an interview on 6/6/2025 at 4:40 p.m., the Administrator stated based on their review of their most recent QAPI programs, call light response and customer service was not listed as an area of focus. The DON stated it was important to address the grievances related to resident care. The DON stated, although in services were essential to educating staff on the importance of providing timely assistance to residents, there must be a system in place to evaluate if the corrective actions were affective. The ADM stated at this time, the facility did not have a system in place to determine if there was improvement in care of resident's in a timely manner. During a review of the facility's undated Policy and Procedure (P/P), titled, Quality Assurance and Performance Improvement (QAPI)Program - Governance and Leadership the P/P indicated the Quality Assurance and Performance Improvement program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the Administrator and governing body. The responsibilities of the QAPI committee are to :collect and analyze performance indicator data and other information, identify , evaluate, monitor and improve facility systems and process that support the delivery of care and services, coordinate the development, implementation ,monitoring and evaluation of performance improvement projects to achieve specific goals. (continued on next page)

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	06/06/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review the facility failed to ensure their QA/QAPI (Quality Assurance/Quality Assurance and Performance Improvement, a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee monitored interventions put in place related to delays in receiving resident care. This deficient practices resulted in the inability of the facility to determine if interventions put in place to improve resident care in a timely manner were affective and placed residents at risk for continued delay in care and services. Findings: During a review of the facility's Grievance Report dated 5/16/2024, the Grievance Report indicated Resident 4 had concerns related to answering of call lights (device used by resident to ask for assistance) in a timely manner. The Grievance Report indicated the facility will continue to address the concern during their QAPI meeting. During a review of the facility's Grievance Report dated 4/15/2025, the Grievance Report indicated Resident 4 had concerns related to resident care, call lights and customer service. The Grievance Report indicated actions taken to resolve the concern was to provide in-service staff on answering call lights in a timely manner. During a review of the facility's Grievance Report dated 5/19/2025, the Grievance Report indicated Resident 5 did not receive resident care in a timely manner. The Grievance Report indicated actions taken to resolve the concern was for the Director of Nursing (DON) to provide in-services to staff on answering call lights in a timely manner. During an interview on 6/6/2025 at 4:40 p.m., the Administrator stated based on their review of their most recent QAPI programs, call light response and customer service was not listed as an area of focus. The DON stated it was important to address the grievances related to resident care. The DON stated, although in services were essential to educating staff on the importance of providing timely assistance to residents, there must be a system in place to evaluate if the corrective actions were affective. The ADM stated at this time, the facility did not have a system in place to determine if there was improvement in care of resident's in a timely manner. During a review of the facility's undated Policy and Procedure (P/P), titled, Quality Assurance and Performance Improvement (QAPI)Program - Governance and Leadership the P/P indicated the Quality Assurance and Performance Improvement program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the Administrator and governing body. The responsibilities of the QAPI committee are to :collect and analyze performance indicator data and other information, identify , evaluate, monitor and improve facility systems and process that support the delivery of care and services, coordinate the development, implementation ,monitoring and evaluation of performance improvement projects to achieve specific goals.