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	07/03/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of the four sampled residents (Resident 1 and Resident 2) change of condition (COC: when there is an alteration in an individual's physical or psychosocial wellbeing) were implemented by: 1. Failing to monitor Resident 1 who was diagnosed with Scabies (a contagious skin condition caused by tiny insects called mites that infest and irritate skin causing intense itching, inflammation, and red patches) after treatment was administered. 2. Failing to initiate a COC on 2/19/2025 when there was a change in Resident 2's skin assessment These deficient practices had the potential to negatively affect the delivery of care and services necessary for Resident 1 who was being treated for scabies and resulted in Resident 2 developing a stage II pressure injury (injury to skin and underlying tissue resulting from prolonged pressure on the skin). Findings: A.During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain by underlying medical condition [diabetes: a disorder characterized by difficulty in blood sugar control and poor wound healing]), infection and inflammation reaction due to indwelling urethral catheter, and functional quadriplegia (complete inability to move due to severe disability or frailty). During a review of Resident 1's history and physical (H&P) dated 2/10/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions as Resident 1 has dementia (a progressive state of decline in mental abilities).During a review of Resident 1's Minimum Data Set (MDS: a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 2 was cognitively impaired. The MDS indicated Resident 1 was dependent on chair/bed-to-chair transfer, toileting hygiene, bathing, lower body (below waist) dressing, required maximal assistance (provides more than half the effort) for lying to sitting on side of bed, required moderate assistance (provides less than half the effort) for personal hygiene, upper body (above waist) dressing, and required supervision for eating and oral hygiene. The MDS indicated Resident 1 utilized a wheelchair and had impairment on both upper (arms/shoulder) extremity and impairment on one side on the lower (hips, legs) extremity. During a concurrent interview and record review on 7/2/2025 at 12:16p.m. with the Infection Preventionist Nurst (IPN), the IPN stated after Resident 1's COC on 5/2/2025, there was no follow up documentation to see if there were any improvements or any adverse reactions from the treatment. IPN stated that when there is a COC, residents are monitored for 72 hours to indicate if the resident is improving or getting worse. B. During a review of Resident 2's Face Sheet, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of encephalopathy (any damage or disease that affects the brain), dementia, and difficulty walking. During a review of Resident 2's H&P dated 2/14/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was moderately impaired for making daily decisions. The MDS indicated Resident 2 required maximal assistance for bathing, required moderate assistance for eating, oral hygiene, toileting hygiene, upper and lower body dressing, personal hygiene, and required supervision for chair/bed-to-chair transfer. The MDS indicated Resident 2 was occasionally incontinent (involuntary) for bladder (an organ that holds urine) and was frequently incontinent for bowel (part of the digestive system.During a review of Resident 2's CNA skin monitoring worksheet (a document in which a visual assessment of the resident's skin is performed when giving a shower) dated 2/15/2025, the CNA monitoring sheet indicated Resident 2 did not have any skin issues. During a review of Resident 2's CNA skin monitoring worksheet dated 2/19/2025, the CNA monitoring sheet indicated on 2/19/2025, there was a wound on the sacrococcyx (fused bone structure that consists of the sacrum [triangular bone at the base of the spine] and coccyx [tail bone]) area. Resident 2's CNA skin monitoring worksheet indicated the Treatment Nurse (TXN) was notified. During a review of Resident 2's Change of Condition (COC) dated 2/22/2025 at 3:09 p.m., the COC indicated Resident 2 had a stage 2 pressure injury, measuring 1.5cm x 1cm. During a concurrent interview and record review on 7/3/2025 at 11:36a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the CNA skin monitoring worksheet dated 2/19/2025 indicated the TXN was notified Resident 2's sacrococcyx wound. RNS 1 stated a COC for Resident 2's skin change was done on 2/22/2025 (3 days later) but should have been done on 2/19/2025. During an interview on 7/3/2025 at 2:34p.m. with the Director of Nursing (DON), the DON stated that the COC is when there is a change of condition in a resident from normal to abnormal and a COC documentation would include the time

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of four sampled residents (Resident 2) received care to prevent pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) to the sacrococcyx area.This deficient practice resulted in Resident 2 developing a stage II pressure injury on the sacrococcyx (fused bone structure that consists of the sacrum [triangular bone at the base of the spine] and coccyx [tail bone]) area and had the potential for risk of infection and pain. During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including encephalopathy (any damage or disease that affects the brain), dementia (group of thinking and social symptoms that interferes with daily functioning), and difficulty walking. During a review of Resident 2's history and physical (H&P) dated 2/14/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's minimum data set (MDS: a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 2 was moderately impaired for making daily decisions. The MDS indicated Resident 2 required maximal assistance (provides more than half the effort) for bathing, required moderate assistance (provides less than half the effort) for eating, oral hygiene, toileting hygiene, upper (above waist) and lower (below waist) body dressing, personal hygiene, and required supervision for chair/bed-to-chair transfer. The MDS indicated Resident 2 was occasionally incontinent (involuntary) for bladder (an organ that holds urine) and was frequently incontinent for bowel (part of the digestive system). During a review of the Body Check dated 2/12/2025 at 12:39 p.m., the body check indicated Resident 2 did not have any skin issues. During a review of the Braden Scale (assessment tool used to predict a resident's risk of developing pressure injuries) dated 2/12/2025 at 12:41p.m., the Braden Scale indicated Resident 2 was at mild risk (score range 15-18) with a score of 17. During a review of Resident 2's CNA skin monitoring worksheet (a document in which a visual assessment of the resident's skin is performed when giving a shower) dated 2/15/2025, the CNA monitoring sheet indicated Resident 2 did not have any skin issues. During a review of Resident 2's CNA skin monitoring worksheet dated 2/19/2025, the CNA monitoring sheet on 2/19/2025 indicated there is a wound on the sacrococcyx area with documentation the Treatment Nurse (TXN) was notified. During a review of Resident 2's Change of Condition (COC) dated 2/22/2025 at 3:09 p.m., the COC indicated Resident 2 had a stage 2 pressure injury. The COC indicated Resident 2 was being changed by a Certified Nursing Assistant (CNA) 1 when CNA 1 noticed the wound on sacrococcyx. measuring 1.5cm x 1cm. During a review of Resident 2's care plan (CP) untitled initiated 2/23/2025, the CP indicated Resident 2 has a stage 2 pressure injury measuring 1.5centimeter (cm: unit of length) by (x) 1cm. During an interview on 7/1/2025 at 3:25p.m. with Resident 2's Family Member 2 (FM 2), FM 1 stated Resident 2 got a bed sore at the facility and indicated the day prior to getting transferred to the General Acute Care Hospital (GACH) on 2/26/2025, the staff had left Resident 2 in her feces for a long time, and it was all over the bed. FM 2 stated the staff would not get Resident 2 up out of bed on a regular basis and would only get out of bed for 30 to 45 minutes with Physical Therapy (PT: diagnose and treat individuals to improve movement). FM 2 stated Resident 2 did not walk, had a diaper that was not changed on a regular basis, and the staff would state they are short-staffed when asked for assistance. During a concurrent interview and record review on 7/2/2025 at 4:00p.m. with the TXN, the TXN stated Resident 2's stage 2 pressure injury would be considered acquired in the and indicated if a resident is lying on their back and not turning much, or due to immobility, the resident can develop a pressure injury. The TXN stated Resident 2 was being changed by a CNA and has a stage 2 measurement of 1.5cm x 1cm. The TXN stated, in two hours, a stage I can develop to a stage 2 if the resident is not cleaned or turned. During an interview on 7/3/2025 at 10:02 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if a resident is not being repositioned or if they sit in urine/feces for too long, it can cause the skin to breakdown. LVN 1 stated this can create pressure injuries to the skin and can become painful. During a concurrent interview and record review on 7/3/2025 at 11:36 a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 2 was incontinent for both bowel and bladder. RNS 1 stated Resident 2's Braden Score dated 2/24/2025 indicated Resident 2 was at moderate risk (score of 13-14) with a score of 13. RNS 1 stated the CNA skin monitoring worksheet dated 2/19/2025 indicated the TXN was notified of Resident 2's skin changes on the sacrococcyx and the COC for Resident 2's skin change was done on 2/22/2025 (3 days later). RNS 1 stated the COC should have been done on the same day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control measures for one of two sample residents (Resident 1) by failing to: 1. Ensure proper Personal Protective Equipment (PPE: equipment worn (gown, gloves, goggles) to help create a barrier between a healthcare worker and germs) was worn for Resident 1 that was on Enhanced Barrier Precaution (EBP: infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs).2. Ensure proper hand hygiene was performed during glove changes.3. Ensure Resident 1's indwelling catheter (or known as Foley catheter, a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) drainage bag was not touching the floor.4. Ensure the rooms were deep cleaned after medication to treat Scabies (a contagious skin condition caused by tiny insects called mites that infest and irritate skin causing intense itching, inflammation, and red patches) were applied. These deficient practices had the potential to transmit infectious microorganisms and increase the spread of infection to all residents and staff in the facilityDuring a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain by underlying medical condition [diabetes: a disorder characterized by difficulty in blood sugar control and poor wound healing]), infection and inflammation reaction due to indwelling urethral catheter, and functional quadriplegia (complete inability to move due to severe disability or frailty). During a review of Resident 1's history and physical (H&P) dated 2/10/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions as Resident 1 had dementia (a progressive state of decline in mental abilities).During a review of Resident 1's minimum data set (MDS: a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 1 was cognitively mildly impaired. The MDS indicated Resident 1 was dependent on chair/bed-to-chair transfer, toileting hygiene, bathing, lower body (below waist) dressing, required maximal assistance (provides more than half the effort) for lying to sitting on side of bed, required moderate assistance (provides less than half the effort) for personal hygiene, upper body (above waist) dressing, and required supervision for eating and oral hygiene. During a review of Resident 1's Change of Condition (COC) dated 5/2/2025 at 2:30p.m., the COC indicated Resident 1 had a rash all over body. The COC indicated Resident 1 had a rash with persistent mild to moderate itching unrelieved by topical treatment or mild antihistamines (medication to alleviate symptoms such as itching). The COC indicated the recommendation for Resident 1 was Permethrin (a medication applied to the entire body to treat scabies) 5% cream. During a review of Resident 1's lab result report 5/2/2025 at 3:32p.m., the lab report indicated Resident 1 tested positive for scabies. During a record review of Resident 1's Medication Administration Record (MAR: electronic medication administration document) dated 5/1/2025 - 5/31/2025, the MAR indicated Resident 1 had an order for Permethrin External Cream with a start date of 5/3/2025. During a record review of Resident 1's Treat Administration Record (TAR: electronic treatment administration document) dated 5/1/2025 - 5/31/2025, the TAR indicated Resident 1 was treated with Permethrin External Cream with a start date of 5/23/2025 and discontinued on 5/25/2025. During a record review of Resident 1's TAR dated 6/1/2025 - 6/3/2025, the TAR indicated Resident 1 was treated with Permethrin External Cream with a start date of 5/26/2025 and discontinued 6/2/2025.During a record review of Resident 1's TAR dated 6/1/2025 - 6/30/2025, the TAR indicated Resident 1 was treated with Permethrin External Cream with a start date of 6/18/2025 every Wed and Sat for itching until 6/25/2025 and must shower resident the next day. During a review of Quality Control Inspection (QCI)-Housekeeping, the QCI indicated Resident 1's room was deep cleaned on the following days:-5/1/2025-5/14/2025-5/28/2025-6/7/2025-6/12/2025-6/15/2025-6/25/2025During an interview on 7/1/2025 at 2:35p.m. with Family Member 1 (FM 1), FM 1 stated Resident 1 had scabies, the staff never wore PPE protection during care and indicated the facility has placed Resident 1 back onto dirty sheets after a shower.During a concurrent observation and interview on 7/1/2025 at 4:01p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 1 is on EBP precautions because she has an indwelling catheter. LVN 2 was observed wearing gloves without prior hand hygiene and taking the blood pressure cuff off Resident 1's right arm without an isolation gown. No hand hygiene was observed after LVN 2 removed her gloves and proceeded to pour water into a cup and opened a straw paper for Resident 1. LVN 2 was observed going back into Resident 1's room, without an isolation gown while administering medication