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	08/15/2025

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 - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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	08/15/2025

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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physicians for four of four sampled residents (Resident 1, Resident 2, Resident 3 and Resident 4) when their appointments for test and/or consultations were missed or not scheduled. These deficient practices resulted in Resident 1's surgery being delayed for five months and had the potential to result in a delay in treatment and services for Residents 2, 3, and 4. a. 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 end stage renal disease ([ESRD] irreversible kidney failure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 1 required partial/moderate assistance (helper does less than half the effort) from facility staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 3/11/2025, the Physician's Order indicated a micro laryngoscopy (a minimally invasive surgical procedure to diagnose and treat various conditions affecting the vocal cords and larynx (voice box) for vocal cord lesion removal was scheduled for Resident 1 on 3/21/2025. During a review of Resident 1's Physician's Order dated 4/10/2025, the Physician's Order indicated an appointment for a cardiac stress test on 4/21/2025 at 7:30 a.m. During a review of Resident 1's Nurses Progress Note dated 6/12/2025, the Nurses Progress Note indicated Resident 1's physician informed Registered Nurse (RN) 1, that Resident 1 needed a micro laryngoscopy for vocal cord lesion removal as soon as possible and Resident 1 had missed two cardiac stress test appointments. The Nurses Progress Note indicated RN 1 would inform the social worker to make another cardiac stress test appointment. During a review of Resident 1's Physician's Progress Note dated 8/1/2025, the Physician's Progress Note indicated Resident 1 should have had a cardiac clearance (a medical evaluation performed by a cardiologist [a doctor who specializes in diagnosing and treating diseases of the heart and blood vessels]) to assess Resident 1's heart health and determine if it was safe for Resident 1 undergo a planned medical procedure, but the cardiac stress test appointments were overlooked by facility. The Physician's Progress Note indicated facility staff were working on scheduling a cardiac stress test and cardiac clearance for Resident 1's surgery (3/21/2025). During a telephone interview on 8/19/2025 at 1:53 p.m., Resident 1's physician stated he called the facility in 6/2025 (exact date unknown), to inquire about and reschedule Resident 1's surgery because Resident 1's surgery had been delayed because he missed his cardiac stress test and cardiac clearance. b. 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 hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidneys due to a blockage in the urinary tract caused by a kidney stone) and degenerative disc disease (a condition where the spinal discs wear down over time due to aging and daily stress). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact, and Resident 2 required supervision or touch assistance (providing verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from facility staff to complete his activities of daily living ADLs. During a review of Resident 2's Physician's Order dated 2/13/2025, the Physician's Order indicated Resident 2 required a follow up appointment with urology (a branch of medicine concerned with the function and disorders of the urinary system) for kidney stones. During a review of Resident 2's Physician's Order dated 5/21/2025, the Physician's Order indicated Resident 2 required a follow up appointment with a neurosurgeon (a medical doctor who diagnoses and treats conditions that affect the nervous system including the brain, spinal cord, and nerves) due to degenerative disc disease During a review of Resident 2's Medical Records, there was no documentation to indicate that Resident 2's urology and neurosurgeon appointments had been scheduled or that Resident 2 had gone to the appointments. c. During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis Parkinson's Disease (a progressive disease of the nervous system marked by tremors, muscular rigidity, and slow, imprecise movements). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired, and Resident 3 required partial/moderate assistance from facility staff to complete his ADLs. During a review of Resident 3's Physician's Order dated 6/02/2025, the Physician's Order

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	08/15/2025

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and 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	08/15/2025

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure four of four sampled residents (Resident 1, Resident 2, Resident 3 and Resident 4), who had orders in place for test and/or consultations, had those orders implemented. These deficient practices resulted in Resident 1's surgery being delayed for five months and had the potential to result in a delay in treatment and services for Residents 2, 3, 4.a. 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 end stage renal disease ([ESRD] irreversible kidney failure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 1 required partial/moderate assistance (helper does less than half the effort) from facility staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 3/11/2025, the Physician's Order indicated a micro laryngoscopy (a minimally invasive surgical procedure to diagnose and treat various conditions affecting the vocal cords and larynx (voice box) for vocal cord lesion removal was scheduled for 3/21/2025. During a review of Resident 1's Physician's Order dated 4/10/2025, the Physician's Order indicated an appointment for a cardiac stress test on 4/21/2025 at 7:30 a.m. During a review of Resident 1's Nurses Progress Note dated 6/12/2025, the Nurses Progress Note indicated Resident 1's physician informed Registered Nurse (RN) 1, that Resident 1 needed a micro laryngoscopy for vocal cord lesion removal as soon as possible and Resident 1 had missed two cardiac stress test appointments. The Nurses Progress Note indicated RN 1 would inform the social worker to make another cardiac stress test appointment. During a review of Resident 1's Physician's Progress Note dated 8/1/2025, the Physician's Progress Note indicated Resident 1 should have had a cardiac clearance (a medical evaluation performed by a cardiologist (a doctor who specializes in diagnosing and treating diseases of the heart and blood vessels) to assess his heart health and determine if it was safe to undergo a planned medical procedure) but appointments were overlooked by facility. The Physician's Progress Note indicated facility staff were working on scheduling a cardiac stress test and a cardiac clearance for surgery. During a telephone interview on 8/19/2025 at 1:53 p.m., Resident1's physician stated he called the facility in 6/2025 (exact date unknown) because Resident 1's surgery had been delayed because Resident 1 missed his cardiac stress test and cardiac clearance. b. 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 a diagnosis of hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidneys due to a blockage in the urinary tract caused by a kidney stone) and degenerative disc disease (a condition where the spinal discs wear down over time due to aging and daily stress). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact, and Resident 2 required supervision or touch assistance (providing verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from facility staff to complete his activities of daily living ADLs. During a review of Resident 2's Physician's Order dated 2/13/2025, the Physician's Order indicated Resident 2 required a follow up appointment with urology (a branch of medicine concerned with the function and disorders of the urinary system) for kidney stones. During a review of Resident 2's Physician's Order dated 5/21/2025, the physician order indicated Resident 2 required a follow up appointment with a neurosurgeon (a medical doctor who diagnoses and treats conditions that affect the nervous system including the brain, spinal cord, and nerves) due to degenerative disc disease During a review of Resident 2's Medical Records, there was no documentation to indicate that Resident 2's urology and neurosurgeon appointments had been scheduled or that Resident 2 had gone to the appointments. c. During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with a diagnosis Parkinson's Disease (a progressive disease of the nervous system marked by tremors, muscular rigidity, and slow, imprecise movements). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired, and Resident 3 required partial/moderate assistance from facility staff to complete activities his of daily living ADLs. During a review of Resident 3's Physician's Order dated 6/02/2025, the Physician's Order indicated Resident 3 had a neurology appointment for 6/11/2025. During a review of Resident 3's Medical Record, there was no documentation to indicated that

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	08/15/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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	08/15/2025

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 0842 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 of four sampled residents (Resident 1), who had a consultation outside of the facility with a cardiologist (a doctor who specializes in the heart and blood vessels) on 3/24/2025, returned to the facility with progress notes and instructions for care that were available for review in Resident 1's medical record. This deficient practice resulted in a delay in scheduling Resident 1's micro laryngoscopy (a minimally invasive surgical procedure to diagnose and treat various conditions affecting the vocal cords and larynx ([voice box]) for vocal cord lesion removal and had the potential for complications occurring based on that delay in surgery.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 end stage renal disease ([ESRD] irreversible kidney failure). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and Resident 1 required partial/moderate assistance (helper does less than half the effort) from facility staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order dated 3/11/2025, the Physician's Order indicated a micro laryngoscopy for vocal cord lesion removal was scheduled for 3/21/2025. During a review of Resident 1's Physician's Order dated 3/19/2025, the Physician's Order indicated Resident 1 had an appointment to see a cardiologist for a cardiology clearance (an evaluation performed by a cardiologist to determine if a patient's heart is healthy enough to undergo a planned surgical procedure) on 3/24/2025. During a review of Resident 1's Medical Records, there was no documentation to indicate consultation note and/or care instructions following Resident 1's cardiologist appointment on 3/24/2025. During an interview on 8/14/2025 at 1:14 p.m., the Social Services Director (SSD) stated she could not recall if Resident 1 went to his cardiology appointment on 3/24/2025. Later the same day the SSD called the cardiologist office to obtain the cardiology progress notes from Resident 1's cardiology appointment on 3/24/2025. During a review of Resident 1's cardiology Progress Notes dated 3/24/2025, the cardiology Progress Notes indicated they were faxed to the facility on 8/14/2025 at 4:23 p.m. During an interview on 8/14/2025 at 1:54 p.m., the Director of Staff Development (DSD) stated when residents leave the facility for doctor appointments, the physician usually transfers the residents back to the facility with orders in a packet, the visit notes take a couple of days to complete. The DSD stated if the resident returns to the facility without orders or instructions for care, the licensed nurses should follow up with the physician who provided the care to obtain those instructions because the facility should know what was discussed during the appointment and what the instructions for care were. During an interview on 8/14/2025 at 2:12 p.m., the Director of Nursing (DON), after reviewing Resident 1's medical record, stated the progress note from Resident 1's cardiology visit on 3/24/2025 was not available in Resident 1's medical record. The DON stated she was made aware that Resident 1 had an appointment on 3/24/2025 but she did not see the note from the cardiologist, assumed Resident 1 had not been seen by the cardiologist and made another appointment to see the cardiologist on 8/13/2025. The DON stated if Resident 1's cardiologist progress notes from his 3/24/2025 appointment had been available for review in Resident 1's medical record, she would have called Resident 1's surgeon (MD 2) to schedule Resident 1's surgery and there would have been no delay. The DON stated if Resident 1 did not have care instructions/notes with him when he returned to the facility from his appointment, the nursing staff should have called the physician's office to obtain the instructions for care, and if after 24 hours the documents were not received, medical records should have been made aware so they could have followed up. During a review of the facility's Policy and Procedure (P/P) titled Location and Storage of Medical Records dated 12/2006, the P/P indicated all current medical records are filed in the Medical Records Department and maintained by the Medical Records Clerk. During a review of the facility's undated P/P titled Appointments the P/P indicated any orders and follow up appointment are to be documented in the electronic record and the MD progress notes to be included in the resident's