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	09/23/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident call light was within reach for two of two sampled resident (Resident 1 and Resident 3).This failure resulted in residents being unable to request assistance and remaining in soiled conditions for an extended period, which compromised their dignity, delayed their care needs, and failed to reasonably accommodate their personal preferences.Findings: During a review of Resident 1's admission Record , the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and heart failure (when the heart muscle becomes weakened or stiff and cannot pump blood). During a review of Resident 1's History and Physical (H& P) dated 8/2/2024, the H&P indicated Resident 1 could make her needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS] resident care screening tool) dated 9/3/2025, the MDS indicated Resident 1 was dependent (helper does all of the effort) for toileting hygiene, and showering/bathing. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and atrial fibrillation (irregular heartbeat). During a review of Resident 3's H& P dated 2/4/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). The MDS indicated assistance may be provided throughout the activity or intermittently for toileting hygiene, shower/bath, and personal hygiene. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/23/2025 at 8:46 a.m. with Certified Nurse Assistant (CNA) 1, inside Resident 1's room, Resident 1 was observed lying in bed. Resident 1's call light was located behind the bed, out of reach. CNA 1 stated the call light should always be within the resident's reach. CNA 1 stated if Resident 1 needed assistance she would not be able to request assistance when needed which could result in unmet needs and could be a safety risk if she tried to get out of bed. Resident 1's incontinence brief was observed to be wet and soiled. CNA 1 stated that she checks Resident 1 every two hours and as needed. CNA 1 acknowledged that the incontinence brief appeared soaked and had been that way from the previous shift. CNA 1 stated that she had planned to change Resident 1 after breakfast, but she had gotten busy with her other residents. CNA 1 stated Resident 1 could develop an infection, pressure ulcers, and feel neglected by being left wet for a long period of time. During a concurrent observation and interview on 9/23/2025 at 9:04 a.m. with CNA 2, inside of Resident 3's room, Resident 3 was observed lying in bed and Resident 3's call light was located behind the bed, out of reach. Resident 3's incontinence brief was observed to be wet and soiled. CNA 2 stated the call light should be within Resident 3's reach for her to call for assistance. CNA 2 stated that Resident 3 may not get assistance in a timely manner for repositioning or toileting if her call light was not within her reach. CNA 2 stated if residents were left wet, that it could cause skin breakdown (when the skin and the underlying tissues are damaged due to factors like prolonged pressure, friction, or excessive moisture) or pressure sores (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). CNA 2 stated that she usually rounds on the residents' every two hours, but she had not gotten to Resident 3 because she was passing out the breakfast trays and assisting residents with eating. During an interview on 9/23/2025 at 9:10 a.m. with Resident 3, Resident 3 stated that the staff does not come and check on her often. Resident 3 stated that she lies in bed for a long time before the staff changes her incontinence brief. Resident 3 stated that when she must wait for a long period of time it makes her feel uncomfortable and neglected. Resident 3 stated that it feels like she was left wet for hours. During an interview on 9/23/2025 at 11:20 a.m. with License Vocational Nurse (LVN) 3, LVN 3 stated that Resident 1 was dependent of care and requires two persons assistance. LVN 3 stated call lights should always be within residents reach to ensure that the residents were able to call for staff promptly for assistance with toileting, personal care, and other needs. LVN 3 stated that if the call light was not within reach, the resident may remain unattended, which could result in falls, prolonged periods of incontinence care, skin breakdown, or discomfort. LVN 3 stated that leaving resident's wet or soiled incontinence brief and not having their call light within reach was not right. LVN 3 stated that it affects their dignity and might make them feel embarrassed or ignored. During an interview on 9/23/2025 at 11:25 a.m. with the Director of Nursing (DON), the DON stated that all staff are expected to check call lights and provide incontinence care regularly. The DON stated that staff were expected to round on the residents every two hours, and document on the computer. The DON stated that it was essential that call lights were always within resident's reach because it allows them to request assistance promptly. The DON stated that if a call light was out of reach, the residents may try to get up on their own, which could lead to falls or injury. The DON stated that residents being left in soiled incontinence briefs increases the risk of skin breakdown, infections, and overall discomfort. The DON stated that ensuring call lights are accessible was a basic part of maintaining resident safety, dignity, and quality of care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 2024, the P&P indicated, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of the facility's policy and procedure (P&P) titled, Perineal Care, [undated], the P&P indicated, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin. Findings: During a review of Resident 1's admission Record (a document containing demographic and diagnostic information) , the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and heart failure (is when the heart muscle becomes weakened or stiff and cannot pump blood). During a review of Resident 1's History and Physical (H& P) dated 8/2/2024, the H&P indicated Resident 1 could make her needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 9/3/2025, the MDS indicated Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for toileting hygiene, and showering/bathing. During a review of Resident 3's admission Record (a document containing demographic and diagnostic information) , the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including type 2 diabetes mellitus, and atrial fibrillation. During a review of Resident 3's History and Physical (H& P) dated 2/4/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 5/22/2025, the MDS indicated Resident 3 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). The MDS indicated assistance may be provided throughout the activity or intermittently for toileting hygiene, shower/bath, and personal hygiene. During a concurrent observation and interview on 9/23/2025 at 8:46 a.m. with Certified Nurse Assistant (CNA) 1, inside Resident 1's room, Resident 1 was observed lying in bed. Resident 1's call light was located behind the bed, out of reach. CNA 1 stated the call light should always be within the resident's reach. CNA 1 stated if Resident 1 needed assistance she would not be able to request assistance when needed which could result in unmet needs and could be a safety risk if she tried to get out of bed. Resident 1's incontinence brief was observed to be wet and soiled. CNA 1 stated that she checks on Resident 1 every two hours and as needed. CNA 1 acknowledged that the incontinence brief appeared soaked and had been that way from the previous shift. CNA 1 stated that she had planned to change Resident 1 after breakfast, but she had gotten busy with her other residents. CNA 1 stated Resident 1 could develop an infection, pressure ulcers, and feel neglected by being left wet for a long period of time. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an concurrent observation and interview on 9/23/2025 at 9:04 a.m. with Certified Nurse Assistant (CNA) 2, inside of Resident 3's room, Resident 3 was observed lying in bed and her call light was located behind the bed, out of reach. Resident 3's incontinence brief was observed to be wet and soiled. CNA 2 stated the call light should be within Resident 3's reach in order for her to call for assistance. CNA 2 stated that Resident 3 may not get assistance in a timely manner for repositioning or toileting if her call light is not within her reach. CNA 2 stated if residents are left wet, that it could cause skin breakdown (is when the skin and the underlying tissues are damaged due to factors like prolonged pressure, friction, or excessive moisture) or pressure sores (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). CNA 2 stated that she usually rounds on the resident's every two hours, but she had not gotten to Resident 3 because she was passing out the breakfast trays and assisting residents with eating. During an interview on 9/23/2025 at 9:10 a.m. with Resident 3, Resident 3 stated that the staff does not come and check on her often. Resident 3 stated that she lies in bed for a long time before the staff changes her incontinence brief. Resident 3 stated that when she has to wait for a long period of time it makes her feel uncomfortable and neglected. Resident 3 stated that it feels like she is left wet for hours. During an interview on 9/23/2025 at 11:20 a.m. with License Vocational Nurse (LVN) 3, LVN 3 stated that Resident 1 is dependent of care and requires two persons assistance. LVN 3 stated call lights should always be within residents reach to ensure that the residents are able to call for staff promptly for assistance with toileting, personal care, and other needs. LVN 3 stated that if the call light is not within reach, the resident may remain unattended, which could result in falls, prolonged periods of incontinence care (providing physical care), skin breakdown, or discomfort. LVN 3 stated that leaving resident's wet or soiled incontinence brief and not having their call light within reach is not right. LVN 3 stated that it affects their dignity and might make them feel embarrassed or ignored. During an interview on 9/23/2025 at 11:25 a.m. with Director of Nursing (DON), DON stated that all staff are expected to check call lights and provide incontinence care regularly. DON stated that staff are expected to round on the residents every two hours, and document in the computer. DON stated that it is essential that call lights are always within a resident's reach because it allows them to request assistance promptly. DON stated that if a call light is out of reach, the resident may try to get up on their own, which could lead to falls or injury. DON stated that residents being left in soiled incontinence briefs, increases the risk of skin breakdown, infections, and overall discomfort. DON stated that ensuring call lights are accessible is a basic part of maintaining resident safety, dignity, and quality of care. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 2024, the P&P indicated, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of the facility's policy and procedure (P&P) titled, Perineal Care, [undated], the P&P indicated, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin.