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	01/08/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of four sampled residents (Resident 33 and Resident 44) discharged to a general acute care hospital (GACH) had a necessary and appropriate transfer and failed to complete assessment or document attempts to meet resident needs. The facility failed to: 1. Ensure a medical necessity for Resident 33's transfer to a GACH 33's the General Acute Care Hospital (GACH) on 12/11/2025 to 12/14/2025 for decreased participation in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), when evidence in the medical record indicated Resident 33 received physical therapy (PT-the treatment of disease, injury, or physical conditions by methods such as massage, heat treatment, and exercise) and occupational therapy (OT-the therapeutic use of self-care, work and play activities to increase independent function, enhance development, and prevent disability) on 10/1/2025 to 12/10/2025 and had improved and exceeded goals in PT and OT 2. Ensure Resident 44's change of condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) on 8/27/2025 was addressed properly through monitoring, reassessing and documenting identified problems in resident's medical records before transferring or discharging the resident to a GACH. Resident 44 was transferred two days later on 8/29/2025. 3.Document the reason for transfer including symptoms, and interventions attempted for Resident 33 and Resident 44 prior to transfer to GACH. These failures resulted in residents being transferred to a GACH without evidence that the facility assessed their needs or attempted to meet those needs prior to discharge. This lack of assessment and planning placed residents at risk for unmet care needs, compromised continuity of care, and potential adverse health outcomes during hospitalization and upon return. Findings: 1.During a review of Resident 33's admission Record , the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses of but not limited to , hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness or inability to move on one side of the body) following cerebral infarction (lack of adequate blood supply to the brain) affecting the left non-dominant side, contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) on the left and right legs, end stage renal disease (ESRD-End Stage Renal Disease-irreversible kidney failure), muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (the wasting or thinning of muscle mass). During a review of Resident 33's Care Plan, date revised 12/8/2023, the Care Plan indicated the focus was Resident/Patient requires assistance and is dependent for Activities of Daily Living with care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion (movement or the ability to move from one place to another), toileting related to.hemiplegia, and hemiparesis following cerebral infarction affecting the left non-dominant side. The goal of the Care Plan (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: 055032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident ADL care needs will be anticipated and met throughout the next review period. The Care Plan interventions indicated to monitor conditions that may contribute to ADL decline and refer to rehabilitation therapy if a decline in ADLs was noted. During a review of Resident 33's Physician Progress Notes, dated 10/9/2025, the Physician Progress Notes indicated Resident 33 was self responsible. The Physician Progress Notes indicated there was no reported decline in responsiveness or new confusion. The Physician Progress Notes indicated Resident 33 had limited mobility and is likely dependent on assistive devices. The Physician Progress Notes indicated when confronted with acute medical symptoms or conditions necessitating immediate attention for Resident 33 the staff has received explicit instructions to promptly trigger emergency medical services (EMS) via 911 and direct patients to the emergency department. During a review of Resident 33's Nursing Progress Notes, dated 12/8/2025, the Nursing Progress Notes indicated, Resident 33 was alert and oriented times three, able to make needs known. Resident made aware regarding doctor order to transfer to GACH for further evaluation related to decrease in participation in ADLs. Resident refused to be transferred to the hospital. Risk and benefit explained to Resident 33, Resident 33 verbalized good understanding and continued to refuse. During a review of Resident 33's Nursing Progress Notes, dated 12/10/2025, the Nursing Progress Notes indicated, the nurse talked with the resident regarding the change of time of transportation arrival.due to emergency room saturation situation the transportation will be moved to 6 pm, but if not, transportation will be tomorrow morning.Resident disappointed with the situation. During a review of Resident 33's Occupational Therapy Discharge summary, dated [DATE] to 12/10/2025, the Occupational Therapy Discharge Summary indicated Resident 33 met the goals for safely washing the face while with setup and clean up assistance on 10/20/2025. The Occupational Therapy Discharge Summary indicated Resident 33 met the goals for safely washing the face while with contact and guarded assistance on 10/30/2025. The Occupational Therapy Discharge Summary indicated Resident 33's Modified Barthel Index (MBI- gives clinicians a quick validating way to measure independence with Activities of Daily Living) Current Level of Functioning (CLOF) Score equaled 19. The Occupational Therapy Discharge Summary indicated Resident 33's Target MBI equaled 18. The Occupational Therapy Discharge Summary indicated Resident 33 was discharged from OT on 12/10/2025. The Occupational Therapy Discharge Summary indicated Resident 33 made gains in skilled OT. During a review of Resident 33's Physical Therapy Encounter Note, dated 12/10/2025, the Physical Therapy Treatment Encounter Note indicated Resident 33 improved on the right knee extension from -40 degrees to -50 degrees. The Physical Therapy Treatment Encounter Note indicated Resident 33 improved on the left knee extension from -30 degrees to -35 degrees. The Physical Therapy Treatment Encounter Note indicated Resident 33 participated in therapeutic exercises with a focus on balance, strength, and functional activity tolerance to enhance muscle strength, improve balance and improve functional performance in order to improve balance for safe functional mobility and increase independence with functional tasks. The Physical Therapy Treatment Encounter Note indicated Resident 33 actively participates with skilled interventions. During a review of Resident 33's Physical Therapy Discharge summary, dated [DATE] to 12/10/2025 indicated Resident 33 was discharged from PT on 12/10/2025. During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 33 had the ability to express wants and ideas. The MDS indicated (continued on next page)

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F 0627

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident 33 had the ability to understand verbal content. The MDS indicated Resident 33 was dependent on nursing staff for toileting hygiene, lower body dressing, putting and taking off shoes, sitting, lying down, standing and transferring. The MDS indicated Resident 33 used a wheelchair. The MDS indicated Resident 33's prior ability with everyday activities needed partial assistance from nursing staff with bathing, dressing, using the toilet, or eating. The MDS indicated Resident 33 had occupational and physical therapy administered for at least 15 minutes a day or on one or more days in the last seven days. The MDS indicated Resident 33 had zero days of the restorative nursing program (RNA-nursing aide program that helps residents to maintain their function and joint mobility)

During an interview on 1/5/2026 at 2:01 p.m. with Resident 33, Resident 33 stated that she was transferred to the hospital on 12/11/ 2025, for three days with the expectation of receiving therapy, but has not received any therapy since returning. Resident 33 stated upon arrival at the hospital, she repeatedly asked, Why am I here? Resident 33 stated that while at the hospital, she underwent dialysis (a treatment that cleanses the blood of waste and excess fluids through a machine when the kidneys have failed).

During an interview on 1/7/2026 at 1:01 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 33 transferred to the GACH on 12/11/2025 for an evaluation. CNA 8 stated there was no changes with Resident 33 participation with ADL.

During an interview on 1/7/2026 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated on 12/11/2025 stated Resident 33 was transferred to the GACH for decrease in participation in activities of daily living. Resident 33 stated she did not see any documentation of a change of condition for a decrease in ADLs. LVN 5 stated there was no documentation in the Nursing Progress Notes regarding a decrease in ADLs prior to Resident 33's transfer to the GACH. LVN 5 stated she does not know if anything was done to prevent Resident 33's hospitalization. LVN 5 stated a COC was dated 12/11/2025 but the COC was blank with no documentation. LVN 5 stated she does not know if Resident 33's ADLs have improved or declined.

During an interview on 1/8/2026 at 1:44 p.m. with Registered Nurse Supervisor (RNS) 3, RNS 3 stated Resident 33 was a dialysis resident and was transferred to the GACH for an evaluation of a decreased participation in ADLs. RNS 3 stated Resident 33 was on RNA.

During an interview on 1/8/2026 at 2:03 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 33 received PT and PT services from 9/29/2025 to 12/10/2025. The DOR stated on 12/10/2025 Resident 33 was discharged from PT and OT. DOR stated Resident 33 did not have a decline. DOR stated Resident 33 improved and exceeded goals for dressing and personal hygiene. The DOR stated on 12/11/2025 Resident 33 returned to custodial care. The DOR stated on 12/11/2025 she was notified Resident 33 transferred to the GACH for a change of condition. The DOR stated a decrease in ADLs is not a hospital diagnosis.

During an interview on 1/8/2026 at 7:12 p.m. with the Director of Nursing (DON), the DON stated on 12/8/2025 Resident 33 had a decrease participation in ADLs. The DON stated there was no documentation from the licensed nurses regarding a decreased participation in ADLs. The DON stated there was no documentation of a change of condition. The DON stated when Resident 33 was discharged from PT and OT, Resident 33 went to custodial care. The DON stated there was no medical necessity and no reason for Resident 33's transfer to the GACH. The DON stated when Resident 33 returned from the GACH Resident 33 was recalculated for new services and was now on skilled services.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/2026 at 7:28 p.m. with the DOR, the DOR stated Resident 33 was re-admitted to the facility back on PT and OT. The DOR stated the PT and OT therapy was reset after three days in the hospital and Resident 33 was admitted again for PT and OT therapy. The DOR stated Resident 33 went to the hospital without a medical necessity. The DOR stated Resident 33 met the goals for PT and OT on 12/10/2025. During a review of Resident 33's GACH Face Sheet, the GACH Face Sheet indicated Resident 33 was admitted go facility on 12/11/2025 at 5:15 p.m. The GACH Face Sheet indicated Resident 33 was admitted to the GACH with a chief complaint of end stage renal disease and elevated lipase (a protein enzyme that breaks down fat and oils into fatty acids and glycerol). During a review of Resident 33's GACH records, titled Physician Progress Notes, dated 12/12/2025, the Physician Progress Notes indicated Resident 33 presented with intermittent abdominal pain. The Physician Progress Notes indicated Resident 33's right upper and lower extremity strength was 5/5, left hemiplegia.sensation is intact with pinprick and light touch stimulation to all extremities. During a review of Resident 33's GACH record, titled General Radiology, dated 12/12/2025, the General Radiology record indicated Resident 33 had a Kidneys Ureters and Bladder (KUB- an x-ray to assess the abdominal pain or to assess kidneys, ureter and bladder). The KUB findings indicated Resident 33 had nonspecific bowel gas. During a review of resident 33's GACH records, titled Physician Progress Notes, dated 12/13/2025, the Physician Progress Notes indicated Resident 33 was very stable from a neurological (problems affecting the nervous system) perspective. The Physician Progress Notes indicated no new recommendation at this time. During a review of Resident 33's Nursing Progress Notes, dated 12/14/2026, the Nursing Progress Notes indicated Resident 33 was readmitted to the facility on [DATE], alert and oriented to name, place, time and situation, stable condition.Per nursing report from the GACH Resident 33 was admitted for abdominal pain, was diagnosed with end stage renal disease and elevated lipase. The Nursing Notes indicated Resident 33 received dialysis at the GACH with two liters of fluid removed. 2. During a review of Resident 44's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] and 9/2/2025 to the facility with diagnoses including dementia (a progressive state of decline in mental abilities), congestive heart failure(CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), generalized muscle weakness and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 44's MDS dated [DATE], the MDS indicated the resident had an intact cognition (ability to think and make decisions) and required partial/moderate assistance (helper does less than half the effort) with bed mobility, and lower body dressing. During a review of Resident 44's Transfer Form dated 8/29/2025, the Transfer Form indicated the resident was transferred to GACH on 8/29/2025 at 3:38 p.m. due to decline in ADL status. During a concurrent interview and record review on 1/8/2026 at 12;14 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 44's Transfer Form dated 8/29/2025, COC Form dated 8/27/2025, and all (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laboratory results and radiology results done on 8/2025 were reviewed. LVN 1 stated the resident had a COC on 8/27/2025 due to a decline in ADL and the Transfer Form indicated the resident had postural imbalance(body is not aligned correctly) with right sided leaning which raised concerns for musculoskeletal(having to with muscles, bones, tendons, ligaments and joints) weakness or neurological involvement(problems with the brain, spinal cord or nerves that disrupt how a person think, move, feel or control basic functions like breathing or balance). LVN 1 stated the resident came back to the facility on 9/2/2025. LVN 1 stated there were no laboratory tests or diagnostic test ordered by the physician when the resident had a change of condition and before discharging to the GACH two days later. During a review of Resident 44's COC dated 8/27/2025 timed at 2:01 p.m., the COC indicated a decline in ADL status started on 8/27/2025. The COC indicated the resident had noticeable regression in physical and postural control. The COC indicated the physician was notified. During a review of Resident 44's OT Treatment Encounter Note dated 8/26 /2025 and 8/27/2025, the Occupational Therapy Treatment Encounter Note indicated the resident actively participate and compliant with skilled interventions (goal directed treatments requiring a therapist's specialized knowledge, judgement, and skill to help clients regain or improve their ability to perform daily activities). During a review of Resident 44's PT Treatment Encounter Note dated 8/26/2025 and 8/28/2025, the Physical Therapy Treatment Encounter Note indicated the following on; 8/26/2025 bed mobility Resident 44 required 26 to 50 percent assistance. 8/28/2025 bed mobility Resident 44 required 26 to 50 percent assistance. 8/26/2025 transfer from sit to stand Resident 44 required 51 to 75 percent assistance. 8/28/2025 transfer from sit to stand the Resident 44 required 51 to 75 percent assistance. 8/26/2025 for ambulation (act of walking), Resident 44 walked five feet with two wheeled walker and required 51 to 75 percent assistance. 8/28/2025 for ambulation, Resident 44 walked five feet with two wheeled walker and required 51 to 75 percent assistance. The Physical Therapy Encounter Notes indicated the resident actively participated with skilled interventions on 8/26/2025 and 8/28/2025. During a review of Resident 44's GACH's Records titled, Physician H&P, dated 8/30/2025 timed at 10:36 a.m., the H&P indicated the resident's chief complaint (main reason the patient sees a physician) was declining ADL. The H&P indicated the resident received 500 milliliters (ml- unit of volume) Normal Saline (sterile solution of salt in sterile water) intravenously (directly into a vein) and resident's serum sodium was 134 milliequivalents per liter (mEq/L- unit of measurement and normal levels of Sodium is between 135-145 milliequivalents per liter). During a concurrent interview and record review on 1/8/2026 at 2:18 p.m. with the Director of Rehabilitation (DOR), Resident 44's Occupational Therapy Treatment Encounter Note dated 8/26/2025, and 8/27/2025 were reviewed. DOR stated the resident actively participated in ADL and based on the OT (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment Notes on 8/27/2025 the resident had improved and indicated no ADL decline. During a concurrent interview and record review on 1/8/2026 at 2:18 p.m. with DOR, Resident 44's Physical Therapy Encounter Note dated 8/26/2025 and 8/28/2025 were reviewed. DOR stated PT Treatment Encounter Note dated 8/26/2025 and 8/28/2025 indicated no decline in mobility and no decline in ADL. DOR stated the resident had improved in terms of ADL before the resident was discharged to GACH. During a concurrent interview and record review on 1/8/2026 at 4:37 p.m. with Director of Nursing (DOR) and Minimum Data Set Nurse (MDSN), Resident 44's electronic chart was reviewed. [NAME] stated the resident had a COC on 8/27/2025 for inability to participate in ADL. MDSN stated there were no laboratory tests or diagnostic tests ordered related to the COC on 8/27/2025. MDSN stated there was no documentation indicating the resident was monitored or the resident was not doing well due to decline in ADL after the COC on 8/27/2025 and to the day the resident was transferred to GACH on 8/29/2025. MDSN stated there was no documentation the resident required to be transferred or discharged to GACH. DON stated she could not recall why the resident was being discharged to the hospital. MDSN stated the physician order for transfer to GACH was ordered on 8/29/2025 and timed at 3:54 p.m. DON stated not monitoring, reassessing the resident after a COC and documenting the necessity of transfer had the potential to result in an inappropriate discharge to the hospital. During a review of the facility's policy and procedure (P&P), titled Transfer or Discharge, undated, the P&P indicated, If the basis for the transfer or discharge is that the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility, the resident's physician (or provider) documents the specific resident needs that cannot be met, this facility's attempt to meet those need, and the receiving facility's service(s) that are available to meet those needs.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a person-centered care plan with measurable interventions was created and implemented for one of two sampled residents (Resident 11), when on 11/20/2025, the resident started vomiting and complained of generalized pain of 10/10. This deficient practice had the potential to negatively impact the delivery of necessary care and services for Resident 11.Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included irritable bowel syndrome (a condition that affects a person's stomach and intestines and can cause abdominal cramping, bloating [uncomfortable feeling of fullness, tightness, or swelling in the abdomen] and change in bowel habits) alcoholic cirrhosis of liver (when long term alcohol use severely damage the liver causing it to harden) with ascites (accumulation of fluid in the abdomen), secondary esophageal varices without bleeding , quadriplegia, (paralysis of both arms, and both legs), contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and cervical disc disorder (condition affecting the intervertebral discs in the cervical spine (neck region) with myelopathy (disorder or injury affecting the spinal cord) and spinal stenosis (condition where the spaces within a person's spine narrow). During a review of Resident 11's Minimum Data Set (MDS- a resident's assessment tool) dated 6/14/2025, the MDS indicated Resident 11 had intact cognitive (ability to understand and be understood by others) skills for daily decision making. The MDS indicated Resident 11 was dependent (helper does all the effort and the resident makes none of the effort to complete the activity) with bed mobility, oral hygiene, toileting hygiene, personal hygiene, shower and upper/lower body dressing. During a review of Resident 11's Nurse's Progress Note dated 11/21/25 at 4:22 p.m., the Nurse's Progress Notes indicated Resident 11 had been vomiting for three days. Resident 11's vital signs (VS-measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate) were taken, the abdomen was firm, and bowel sounds were active in all quadrants (areas). The notes indicated Resident 11 was placed on nothing by mouth (NPO) status, except for sips of water. During a review of Nurse's Progress Note dated 11/21/25 at 7:20 p.m., the note indicated Resident 11 had been vomiting throughout the day. During a review of Resident 11' s change of condition ([COC] a sudden, clinically important deviation from a person's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) dated 11/22/25 timed at 3:37 p.m., the COC indicated Resident 11 was unable to eat, or drink, and eat adequate amount of food and fluid, nausea (unpleasant sensation or discomfort in the stomach) and vomiting started 11/20/25. The COC indicated Resident 11's primary care physician was notified (date/time and recommendation not indicated). The COC indicated decreased appetite/fluid intake and unable to keep food down. During a concurrent interview and record review on 1/8/2026, at 3:11 p.m. with LVN 3, Resident 11's Progress Notes dated 11/21/25, Weights and Vital Summary dated 11/25 were reviewed. LVN 3 stated on 11/21/2025, Resident 11 vomited twice during his shift (3:00 p.m. to 11:00 p.m.) LVN 3 stated the first vomitus consisted of food the resident had eaten. He did not observe the second episode, as the RN Supervisor (RNS) 2 assessed Resident 11 at that time. LVN 3 stated there was no documentation of Resident 11's assessment to include color, and smell of vomitus, abdominal assessment and VS. LVN 3 stated a COC report and care plan were not initiated and Resident 11 was not closely monitored. LVN 3 stated a proper assessment should include evaluating the color and smell of vomitus, recent intake, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the resident's physical state. He stated no assessment was documented, and that meant the assessment was not done. LVN 3 stated residents should be monitored closely at least every one to two hours. During a concurrent interview and record review on 11/8/26 at 4:15 p.m., with Registered Nurse Supervisor (RNS) 3, Resident 11's Progress Notes dated 11/20/25 to 11/23/25, COC Evaluation dated 11/22/25, Weights and Vital Summary dated 11/25, Physician Orders, Medication Administration Record (MAR) dated 11/25, and Pain Assessment were reviewed. RNS 3 stated Resident 11 began vomiting on 11/20/25 and the COC was not initiated until 11/22/25 (2 days later). RNS 3 stated Resident 11's complained of pain and vomiting was not care planned RNS 3 stated a person-centered care plan with measurable interventions should have been created and implemented for Resident 11, when on 11/20/2025, the resident started vomiting and complained of generalized pain of 10/10. RNS 3 stated a care plan serves as a guide for licensed nurses to provide treatment and care tailored to each resident's individual needs.During a review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team dated 8/25/21, the P&P indicated The facility's interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven (7) days of completion of the comprehensive assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary Team which includes but is not necessarily limited to the following: The residents' attending PhysicianA registered nurse with responsibility for the residentThe charge nurse responsible for resident careThe dietary manager/dieticianNursing assistants with responsibility for the residents etc. Cross Reference F697 and F684

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 11), was provided needed care and services when the resident had a change of condition ([COC] a sudden, clinically important deviation from a person's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) on 11/21/25. The facility failed to: 1. Follow Resident 11's Nurse Practitioner's (NP) order from a text message communication to Registered Nurse Supervisor (RNS 3) dated 11/22/25 at 1:35 p.m., which indicated to transfer Resident 11 to the general acute care hospital (GACH) immediately for magnetic resonance imaging (MRI- process of taking pictures of organs and tissues inside the body to dictate or diagnosis diseases, and monitor treatment) and further evaluation due to Resident 11 having symptoms of abdominal and arm pain rated at 10 out of 10 on a pain scale rating (where 0 to 3= mild pain, 4 to 7 =moderate pain, 8 to 10 = severe pain, and 10 = worse pain possible), concern of dehydration and esophageal varices (swollen enlarged, veins in the lining of the esophagus [food pipe], that can become weaken, rupture, and cause sudden, severe, and life-threatening internal bleeding).2. Document Resident 11's NP's text message orders dated 11/22/25, which indicated to transfer Resident 11 to a GACH in the resident's medical record for care continuity.3. Follow Resident 11's NP's text message orders dated 11/21/25, which indicated to give Resident 11 Tylenol (pain medication) suppository (inserted into anus), use warm compress to the abdomen for comfort and reposition to reduce discomfort when Resident 11 complained of a sharp stubbing pain rated at 10/10 to her abdomen and had been vomiting (throw up) for three days4. Follow NP's orders to transfer Resident 11 to the GACH on 11/22/25 instead of the Director of Nursing (DON)'s order which indicated not to transfer the resident to the GACH per progress notes dated 11/23/25 at 5:50pm.5. Ensure timely completion of STAT (immediately) laboratory tests as ordered by the NP on 11/22/25 at 7:13 p.m., without waiting until 11/23/25 at 8:00 a.m., (approximately 13 hours) after the orders were received. 6. Ensure a person-centered care plan with measurable interventions was created and implemented for Resident 11, when on 11/20/2025, the resident started vomiting and complained of generalized pain of 10/10. 7. Follow its policy and procedures (P/P) titled Transfer or discharge dated 8/2018, which indicated to transfer residents as necessary for the resident's welfare and if the resident's needs could not be met in the facility These failures resulted in 30 hours delay in transferring Resident 11 to the GACH from the time the NP gave the transfer order on 11/22/2025 at 1:35 p.m. On 11/23/2025, Resident 11 was transferred to GACH after the resident started vomiting blood, received one unit of blood transfusion (replacement of loss blood) and underwent a therapeutic paracentesis (medical procedure performed to remove excess fluid from the abdomen for symptom relief).Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included irritable bowel syndrome (a condition that affects a person's stomach and intestines and can cause abdominal cramping, bloating [uncomfortable feeling of fullness, tightness, or swelling in the abdomen] and change in bowel habits) alcoholic cirrhosis of liver (when long term alcohol use severely damage the liver causing it to harden) with ascites (accumulation of fluid in the abdomen), secondary esophageal varices without bleeding , quadriplegia, (paralysis of both arms, and both legs), contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and cervical disc disorder (condition affecting the intervertebral discs (spine) in the cervical spine (neck region) with myelopathy (disorder or injury affecting the spinal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	cord) and spinal stenosis (condition where the spaces within a person's spine narrow). During a review of Resident 11's Minimum Data Set (MDS- a resident's assessment tool) dated 6/14/2025, the MDS indicated Resident 11 had intact cognitive (ability to understand and be understood by others) skills for daily decision making. The MDS indicated Resident 11 was dependent (helper does all the effort and the resident makes none of the effort to complete the activity) with bed mobility, oral hygiene, toileting hygiene, personal hygiene, shower and upper/lower body dressing. During a review of Resident 11's Nurse's Progress Notes dated 11/21/25 at 3:27 p.m., the Nurse's Progress Notes indicated Resident 11 refused gabapentin (medication used to treat pain) 300 milligram (mg-unit of measurement). The Nurse's Progress Note indicated Resident 11 stated she did not want to take the medication as she did not want to throw up. During a review of Resident 11's Nurse's Progress Notes dated 11/21/25 at 3:33 p.m., the Nurse's Progress Notes indicated Resident 11 refused lactulose (medication used to treat constipation) due to recurrent vomiting. The Nurse's Progress Notes indicated Resident 11 stated she did not want to vomit and felt the medication did not work for her. During a review of Resident 11's Nurse's Progress Note dated 11/21/25 at 4:22 p.m., the Nurse's Progress Notes indicated Resident 11 had been vomiting for three days. Resident 11's vital signs (VS-measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate) were taken, the abdomen was firm, and bowel sounds were active in all quadrants (areas). The notes indicated Resident 11 was placed on nothing by mouth (NPO) status, except for sips of water. During a review of Nurse's Progress Note dated 11/21/25 at 7:20 p.m., the note indicated Resident 11 had been vomiting throughout the day. During a review of text message exchanges between RNS 3 and the NP dated 11/21/25 (unknown time), the text message indicated RNS 3 reported that Resident 11 had been vomiting for three days, complained of a sharp stabbing pain rated at 10/10 to her abdomen and arm. RNS 3 asked for options for Resident 1's pain of 10/10. The NP responded indicating for pain control use Tylenol suppository (if available), warm compress to the abdomen for comfort and reposition to reduce discomfort. During a review of text message exchanges between RNS 3 and the NP dated 11/22/25 at 1:35 p.m., the text messages indicated instructions from the NP to transfer Resident 11 to the GACH immediately due to vomiting for three days, abdominal and arm pain rated 10/10, concerns for dehydration (body loses more fluid than it takes in) and possible esophageal varices. The NP indicated Resident 11 must be sent out to a GACH immediately for magnetic resonance imaging (MRI-a test that creates clear images of structures inside the body) and further evaluation. During a review of Resident 11 s COC Evaluation dated 11/22/25 timed at 3:37 p.m., the COC indicated Resident 11 was unable to eat, or drink, and eat adequate amount of food and fluid, nausea (unpleasant sensation or discomfort in the stomach) and vomiting started 11/20/25. The COC indicated Resident 11's primary care physician was notified (date/time and recommendation not indicated). The COC indicated decreased appetite/fluid intake and unable to keep food down. During a review of text message exchanges between RNS 3 and the NP dated 11/22/25 at 6:06 p.m., NP asked RNS 3 if Resident 11 was transferred to GACH. RNS 3 responded that the RN Supervisor (name unknown) from 7 a.m. to 3 p.m., shift told her the Director of Nursing (DON) advised not to take Resident 11 to the GACH, to start intravenous (IV-through the vein) fluids and STAT (immediately) labs. RNS 3's text message also indicated Resident 11 had vomiting with pain and abdominal discomfort. NP responded If the DON is taking over this case, please follow her direction for now, continue IV hydration and complete the STAT Complete Blood Count (CBC) - blood test that measures several components of the resident's blood) , Comprehensive Metabolic Profile ([CMP] - blood test that measures 14 different substances to evaluate the body's chemical balance, Lipase (blood test) and Lactate (blood test) as ordered. Monitor the resident closely and notify me (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	immediately of any worsening abdominal pain, vomiting, changes in vital signs, or signs of dehydration.During a review of Nurse's Progress Note dated 11/23/25 at 5:50 p.m.,the note indicated Resident 11 was transferred to GACH due to esophageal (throat) pain rated at 10/10. The note indicated Resident 11 had nausea and red-colored vomitus (contents of the stomach that have come up through the mouth) and refused all medications because of their taste and smell. The Nurse's Progress Note indicated Resident 11 was scheduled to be transferred to the GACH for further evaluation on 11/22/25, during the 7:00 a.m. to 3:00 p.m. shift per physician's order. The note indicated according to the DON Resident 11 was already given IV hydration and STAT CBC tests done. The NP was informed and instructed staff to follow the DON's orders and notify her if symptoms worsened. During a review of Resident 11's GACH's History and Physical (H&P) dated 11/23/25 at 11:42 p.m., the H&P indicated Resident 11 arrived for hematemesis (blood in vomitus) and reported severe pain. The H&P indicated Resident 11 reported vomiting blood that began approximately two weeks ago and on 11/23/2025 characterized by a copper (metallic) taste and a small amount of visible blood. During a review of Resident 11's GACH's Discharge summary dated [DATE], the report indicated Resident 11 was admitted to the GACH on 11/23/25 and discharged on 11/26/25 (a total of 3 days). The report indicated Resident 11 presented to the emergency room (ER) with hematemesis (blood in the vomit) and severe pain, which the resident reported started 2 weeks prior. The report indicated Resident 11 underwent Esophagogastroduodenoscopy (EGD diagnostic procedure where a flexible tube with a camera (endoscope) is inserted through the mouth to examine the esophagus, stomach, and the first part of the small intestine) on 11/25/25 with minimal esophageal varices and gastritis (inflammation of the stomach's inner lining). Resident 11 started on Proton Pump Inhibitor (PPI - medications to reduce stomach acid production) IV (drip.(infusion) Resident 11 underwent therapeutic paracentesis on 11/26/25 with 3.6 liters of fluid removed. Resident 11 received one unit of packed red blood cells (PRBC- blood) transfusion. During an interview on 1/5/2026 at 10:45 a.m., Resident 11 stated she was hospitalized on 11/2025 and returned to the facility after two days. Resident 11 stated she had severe abdominal pain with nausea, vomiting and vomiting with blood that started on 11/20/2025. Resident 11 stated she was transferred to the GACH the evening of 11/23/2025. During an interview on 1/8/2026 at 11:26 a.m. with Certified Nurse Assistant (CNA 3), CNA 3 stated on 11/22/25 (unknown time) she observed Resident 11 vomit twice while she was in the resident's room. CNA 3 stated she notified the Licensed Vocational Nurse (LVN) (name unknown) and the LVN assessed Resident 11. CNA 3 stated Resident 11 told the LVN that she was nauseous, and her abdominal pain was more severe than usual. CNA 3 stated the LVN offered Resident 11 medication to stop her from vomiting but Resident 11 refused stating she did not want to take it because she was afraid it would make her vomit During an interview on 1/8/26 at 11:37 a.m. with CNA 4, CNA 4 stated on 11/22/25 at 12:30 p.m., she informed the charge nurse Resident 11 was complaining of feeling sick and nauseous. During a telephone interview on 1/8/2026 at 12:03 p.m., with the NP, the NP stated on 11/21/25 RNS 3 notified her that Resident 11 was vomiting. The NP advised RNS 3 to monitor Resident 11 and inform her of any changes. On 11/22/25 the NP ordered lab test, and IV fluids. The NP stated RNS 3 did not notify her that Resident 11 vomited blood. The NP stated she ordered NPO and notified Resident 11's primary doctor that the resident was vomiting blood. The NP stated RNS 3 sent a text message on 11/22/25 reporting Resident 11 was vomiting. The NP responded with a text message asking if Resident 11 was vomiting blood, and RNS 3 reported on 11/22/25 the resident consumed Jello despite being NPO at 12:00pm. The NP stated that around midnight on 11/22/25, the RNS 4 texted her stating Resident 11 was vomiting and the vomitus appeared reddish. The NP stated on 11/23/25 at 6:00 p.m., she determined Resident 11 needed to be transferred to the GACH due to inability to maintain (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	adequate oral intake, blood in the vomit, and abdominal cramping. The NP stated Resident 11's primary care physician was informed, as he was included in the text messages. During a concurrent interview and record review on 1/8/2026, at 3:11 p.m. with LVN 3, Resident 11's Progress Notes dated 11/21/25, Weights and Vital Summary dated 11/25 were reviewed. LVN 3 stated on 11/21/2025, Resident 11 vomited twice during his shift (3:00 p.m. to 11:00 p.m.) LVN 3 stated the first vomitus consisted of food the resident had eaten. He did not observe the second episode, as the RN Supervisor (RNS) 2 assessed Resident 11 at that time. LVN 3 stated there was no documentation of Resident 11's assessment to include color, and smell of vomitus, abdominal assessment and VS. LVN 3 stated a COC report and care plan were not initiated and Resident 11 was not closely monitored. LVN 3 stated a proper assessment should include evaluating the color and smell of vomitus, recent intake, and the resident's physical state. He stated no assessment was documented, and that meant the assessment was not done. LVN 3 stated residents should be monitored closely at least every one to two hours. During a concurrent interview and record review on 1/8/26 at 4:15 p.m., with RNS 3, Resident 11's Progress Notes dated 11/20/25 to 11/23/25, COC Evaluation dated 11/22/25, Weights and Vital Summary dated 11/25, Physician Orders, Medication Administration Record (MAR) dated 11/2025, and Pain assessment dated 11/2025 were reviewed. RNS 3 stated Resident 11 began vomiting on 11/20/25 and the COC was not initiated until 11/22/25 (2 days later). RNS 3 stated Resident 11 had been refusing to take medications since 11/21/25 due to fear of vomiting. RNS 3 stated on 11/21/25, the NP was notified about Resident 11's vomiting and the NP ordered the resident to be placed on NPO. RNS 3 stated on 11/22/25 at 5:00 p.m., Resident 11's family member (FM 1) requested to see the resident's doctor and RNS 3 contacted the NP, at 7:13 p.m., and the NP ordered STAT lab tests, and IV fluids. RNS 3 stated Resident 11 was started on IV fluids at 8:00 p.m. She further stated lab tests were not performed until 11/23/25 at 8:00 a.m. (13 hours after the orders received). RNS 3 stated STAT lab orders were supposed to be completed within four hours, RNS 3 stated she was unsure why Resident 11's care was delayed. RNS 3 stated given Resident 11 had been vomiting since 11/20/25, complained of pain at 10/10 on 11/21/25, and was refusing medications due to fear of vomiting, Resident should have been transferred to a GACH when the NP gave the order on 11/22/25. RNS 3 stated she did not know why the order was not entered on Resident 11's electronic health record (EHR), and why Resident 11 was not transferred to the GACH on 11/22/25. RNS 3 stated the delay in providing needed care and services to Resident 11 and per the NP's orders placed Resident 11 at risk for harm. During a concurrent interview and record review on 1/8/26 at 6:54 p.m., with the Director of Nursing (DON), Resident 11's Progress Note dated 11/23/25 at 5:50 p.m., was reviewed. The DON stated she did not give any instructions to LVN 6 not to transfer Resident 11 to the GACH on 11/22/25 and did not know why LVN 6 documented such. The DON did not respond when told there was a text message conversation from the NP and RNS 3 on 11/22/25 to transfer Resident 11 to GACH. The DON stated when a resident had a COC, the resident should be monitored every hour, vital signs taken, and assessments documented. She stated there was no COC initiated for Resident 11's vomiting until 11/22/25, no COC for Resident 11's complaint of pain rated 10/10 on 11/21/25, and no care plan initiated to address Resident 1's vomiting and pain. The DON stated the importance of having a care plan was for staff to know interventions needed for Resident 11. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or status dated 2/2021, the P&P indicated the facility promptly notified the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition.The nurse will notify residents attending physicians on call when there had been a/ an:An accident or incident involving the residentDiscovery of injuries of an unknown sourceSignificant change in the residents' (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	physical/emotional/ mental conditionNeed to transfer the resident to a hospital/treatment centerSpecific instructions to notify the physician of changes in resident's condition. In addition to notifying the residents and /or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition or status. During a review of the facility's P&P titled, Transfer or discharge dated 8/2018, indicated transfers or discharges may be necessary to protect the health and well-being of the residents:If the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The facility will notify the resident's attending physician for transfer to the hospital for treatmentNotify the receiving facility that the transfer is being madeNotify the representative or family member. Cross reference to F697

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F 0689

Level of Harm - 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 seven sampled residents (Resident 88), who was at risk for falls, had fall precautions in place to prevent the resident from falling on 10/13/2025 at 9 p.m., and 10/14/25 at approximately 1 a.m. (approximately 4 hours apart).The facility failed to:1.Update Resident 88's care plan titled Unwitnessed Fall to include interventions such as a bed alarm (fall prevention device that alerts caregivers when a patient attempts to get out of bed), landing pads (foam pads placed on the floor alongside a bed to cushion the impact of a person falling), and maintaining the resident's bed in the lowest position after Resident 88's first fall on 10/13/2025 at 9:00 p.m. 2. Ensure Resident 88 was monitored every hour following a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status without which immediate intervention, may result in complications or death) on 10/13/2025. 3.Implement additional safety measures such as one-on-one supervision or move Resident 11 to a room closer to the nurses' station, despite multiple falls and high-fall risk status. 4. Follow its policy and procedure (P&P), titled Accidents and Incidents-Investigating and Reporting, which indicated the facility will collect and evaluate information to determine the cause of a fall and identify pertinent interventions to prevent subsequent falls. These failures resulted in Resident 88 experiencing two falls four hours apart on 10/13/2025, sustaining a laceration (a deep cut, tear, or rip in the skin) to the left forehead, generalized body bruises, and skin tears on both hands and left arm. Resident 88 was transferred to a general acute care hospital (GACH) on 10/14/2025, where treatment included closure of the forehead laceration with steri-strips (sterile noninvasive adhesive strips used to close and support minor, shallow cuts and surgical incisions).5. The facility failed to ensure that the front door was equipped with an active alarm on the inside and alarms on three of four emergency exit doors were activated. This failure had the potential to compromise resident safety by not alerting staff when doors were accessed from the inside.Findings:

During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 88's diagnoses included history of falling, cardiac pacemaker (medical device designed to regulate or maintain the heart's rhythm), end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), and difficulty walking.

During a review of Resident 88's Nursing Documentations Evaluation dated 12/3/24 at 11:49 p.m., the evaluation indicated fall risk factors included history of falls, poor safety judgment, impaired balance and unsteady gait (walking).

During a review of Resident 88's care plan, titled Resident is at risk for falls, dated 2/2/2025, the care plan goal indicated Resident 88 will be free from serious injury. The care plan interventions included to maintain a clutter-free environment in the resident's room and consistent furniture, place the call light in reach while the resident was in bed or close in proximity to the bed, remind the resident to use the call light when attempting to ambulate or transfer and to place all necessary personal items within reach.

During a review of Resident 88's History and Physical (H&P), dated 9/24/2025, the H&P indicated Resident 88 had fluctuating capacity to understand and make decisions.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 88's Minimum Data Set (MDS-a resident assessment tool), dated 9/25/2025, the MDS indicated Resident 88 had the ability to express ideas and wants. The MDS indicated Resident 88 had the ability to understand others. Resident 88 was dependent (helper does all of the effort) on staff for help with toileting, showering, lower body dressing, and putting on and taking off shoes. The MDS indicated Resident 88 needed substantial to maximal assistance (helper does more than half the effort) from nursing staff with walking, upper body dressing, sitting, lying down, standing, and transferring. The MDS indicated Resident 88 did not use any assistive device (a mobility aid that provides support, stability, and balance for people with walking difficulties). During a review of Resident 88's care plan, titled Resident is at risk for falls: history of repeated falls dated 6/12/2025 revised 1/7/2026, the care plan interventions indicated to place the call light within reach, maintain a clutter free environment and close monitoring throughout the shift. During a review of Resident 88's care plan titled Resident was observed on the floor on the left side of the bed dated 9/9/25 revised on 1/7/2026, the care plan interventions included neuro checks (assessments to evaluate the mental status) for 72 hours, educate the resident on the importance of not ambulating without assistance, using the call light for assistance, engaging in independent activities, and toilet resident before and after meals, and at bedtime. During a review of Resident 88's care plan titled Unwitnessed fall dated 10/13/2025 revised 1/7/2026, the care plan interventions indicated assess vital signs and level of consciousness, check for pain, perform a head to toe assessment for any signs of injury. During a review of Resident 88's COC Evaluation dated 10/13/2025 at 9:48 p.m., the COC indicated Resident 88 had an unwitnessed fall. The COC indicated on 10/13/2025 at 3:00 p.m., Resident 88 was observed in bed, alert and verbally responsive. At approximately 9 p.m., Certified Nursing Assistant (CNA) notified Licensed Vocational Nurse (LVN 4) that Resident 88 was found on the floor. The note indicated Resident 88 had no apparent injuries and was unable to verbalize what happened when asked. During a review of Resident 88's COC Evaluation dated 10/14/2025 at 12:55 a.m., the COC indicated Resident 88 was found laying on the floor on his left side facing the door. The COC indicated resident sustained a one inch laceration to the left side of the forehead. Resident 88 verbalized that he wanted to go to the washroom when he fell. During a review of Resident 88's Emergency Department Hospital Admission report dated 10/14/2025, the report indicated Resident 88 presented to the GACH with a left forehead laceration that required stitches (medical threads used to hold skin and tissue together while the body heals) with steri-strips. The report indicated Resident 88 had skin tears to the left elbow, left forearm, and hands covered with gauze (wound dressing). The report indicated Resident 88 had generalized bruising and scabs (protective crust over a wound) to his body (sites not indicated). During an interview on 1/07/2026 at 9:19 a.m. with CNA 6, CNA 6 stated Resident 88 was confused and required constant assistance with toileting. CNA 6 stated on 10/14/2025, Resident 88 fell while attempting to walk to the bathroom. CNA 6 stated resident was assessed as high risk for falls and should have been monitored or supervised every two hours. During a concurrent interview and record review on 1/07/2026 at 9:36 a.m. with LVN 2, Resident 88's COCs dated 10/13/2025 and 10/14/2025, and care plan titled Resident is at High Risk for Falls dated 6/12/2025 were reviewed. LVN 2 stated the COC indicated Resident 88 fell on [DATE] at 9:00 p.m., (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and had a second fall at approximately 1:00 a.m., on 10/14/2025 (4 hours apart). LVN 2 stated on 10/13/2025 at 9:00 p.m., Resident 88 was found lying on the floor after attempting to go to the bathroom. LVN 2 stated Resident 88 required assistance with ambulation, had a second fall on 10/14/2025 which resulted in a one-inch laceration on the forehead after the second fall. LVN 2 stated Resident 88 was assessed at high risk for falls, had a history of falls but did not have interventions in place such as a bed alarm and frequent rounding to prevent further falls. During an interview on 1/07/2026 at 10:19 a.m. with CNA 7, CNA 7 stated she was assigned to Resident 88 on 10/13/2025. CNA 7 stated at 5:30 p.m., she assisted Resident 88 with dinner in his room. CNA 7 stated at 6:30 p.m., while collecting trays, she observed Resident 88 again. CNA 7 stated the next time she saw Resident 88 was after the fall at 9:00 p.m. on 10/13/25. CNA 7 stated Resident 88 frequently attempted to get up without assistance. During a concurrent interview and record review on 1/07/2026 at 3:30 p.m., with LVN 4, Resident 88's care plan titled Unwitnessed Fall dated 10/13/2025 was reviewed. LVN 4 stated the care plan did not include interventions such as bed alarms or landing pads after Resident 88's fall on 10/13/2025 at 9:00 p.m. LVN 4 stated Resident 88 experienced two falls: the first on 10/13/2025 at 9:00 p.m., when the resident was found sitting next to the closet, and the second fall on 10/14/2025 at 1 a.m. He stated fall prevention measures such as landing pads and bed alarms should have been included in Resident 88's care plan but they were not. During an interview on 1/08/2026 at 1:15 p.m. with Registered Nurse Supervisor (RNS) 3, RNS 3 stated Resident 88 fell on [DATE] at 9:00 p.m. and Resident 88's fall care plan updated on 10/13/2025 did not include new safety measures such as bed alarm or any new fall precaution measures to prevent further falls. RNS 3 stated Resident 88 fell again on 10/14/2025 at 1 a.m. RNS 3 stated the falls could have been prevented with more frequent rounding (at least every one to two hours), moving Resident 88 to a room closer to the nurses' station, and implementing a bed alarm. During a concurrent interview and record review on 1/08/2026 at 6:54 p.m. with the Director of Nursing (DON), Resident 88's care plan titled Unwitnessed Fall dated 10/13/2025 was reviewed. The DON stated the care plan did not include interventions such as landing pads or a bed alarm following the fall on 10/13/2025 at 9:00 p.m. The DON stated Resident 88 fell again on 10/14/2025 and sustained a laceration on the forehead. The DON stated Resident 88 was at high risk for falls and required supervision and assistance. She stated interventions such as a bed alarm, one-on-one supervision, and landing pads should have been implemented but were not. The DON stated the interventions in Resident 88's care plan were insufficient to prevent additional falls. The DON stated Resident 88 sustained an injury after the second fall on 10/14/2025 which required evaluation and treatment at a GACH. During a review of the facility's Policy and Procedure (P&P), titled Accidents and Incidents-Investigating and Reporting, date revised 3/2018, the P&P indicated The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form . any corrective action taken . If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance) . During a review of the facility's P&P, titled Accidents and Incidents-Investigating and Reporting, date revised 3/2018, the P&P indicated The staff and physician will continue to collect and evaluate (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Earlwood	20820 Earl Street Torrance, CA 90503

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F 0689 Level of Harm - Actual harm Residents Affected - Few	information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. 5. During a concurrent observation and interview on 1/7/2026 at 6:00 a.m. with the Registered Nurse Supervisor 1 (RNS 1), observed the front door and four exit doors were accessed from inside the building. The alarms on three exit doors were not activated. RNS 1 stated the front door does not have an alarm and can simply be pushed open. She stated the doors were not alarmed because staff frequently use them to enter and exit the building, and a key was required to turn the alarms on and off, only supervisors have these keys. RNS 1 stated exit doors should always remain alarmed and the front door should be alarmed when the front lobby was closed to help ensure resident safety. RNS 1 stated the alarms were intended to alert staff of a possible elopement (leaving the facility unsupervised and without authorization). During an observation and interview on 1/7/2026 at 6:45 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 was observed opening the exit door and the alarm did not activate. CNA 1 stated that this door was used by staff to take linen barrels to the laundry. CNA 1 stated the door should have been alarmed from the inside to alert staff when it was opened. CNA 1 stated that the lack of an active alarm posed a risk for resident to elope, as staff would not be aware if a resident exited through the door. During an interview on 1/7/2026 at 7:35 a.m. with the Administrator (ADM), the ADM stated she was made aware alarms on three of the four exit doors were not activated from the inside and the front door did not have an alarm to alert staff when opened. The ADM stated this posed a safety risk, as residents could elope without staff being aware if the doors were not alarmed. During a review of the policy and procedure (P&P) titled Security Plan (undated) the P&P indicated the facility has established a security plan to help protect the safety of residents/patients, staff and visitors. Exterior building security: a. This center has a schedule for locking/unlocking of exterior doors during night time hours, including persons responsible. b. This center follows a schedule to inspect outdoor lighting adequacy Interior building security: a. This center's security plan includes, if applicable, a plan for stairwell protection. The plan may include descriptions of door security alarms/keypads and titles of persons responsible for updating/changing entry codes, use of cameras and camera monitoring protocols, or other processes used for stairwell protection. b. This center's security plan includes a schedule to inspect indoor lighting adequacy. c. The center's plan also contemplates resident-specific security needs, including: 1.Security measures for special units. 2. Risk for resident elopement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Use of electronic alarms systems and communication call bells.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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 11) who complained of stomach and arm pain rated at 10/10, on a pain scale rating of 0-10 (where 0 to 3= mild pain, 4 to 7 =moderate pain, 8 to 10 = severe pain, and 10 = the worse pain possible) was assessed, medicated and monitored. The facility failed to: 1. Ensure Registered Nurse Supervisor (RNS) 3 assessed and monitored Resident 11's pain after Resident 11 complained of severe pain of 10/10 on 11/21/25. 2. Ensure RNS 3 administered pain medication to Resident 11 when on 11/21/25 at 2:59 p.m., Resident 11 complained of severe pain rated at 10/10, as documented in the Nurses Progress notes on 11/21/25 at 2:59 p.m.3. Develop an individualized care plan for Resident 11 with interventions to monitor, prevent or manage Resident 11's pain. 4. Offer Resident 11, non-pharmacologic interventions (approaches that do not involve medications including heat, repositioning, relaxation, massage, exercise) per the Physician's order on 6/9/25 and the Nurse Practitioner's (NP) text message order on 11/21/25, which indicated to use warm compresses to the abdomen for comfort, relaxation breathing, and repositioning to reduce discomfort. 5. Document the NP's text message orders dated 11/21/25 which indicated staff should provide non-pharmacological pain interventions to Resident 11.6. Follow the facility's policy and procedures (P&P) titled Pain Management dated 8/25/21, which indicated the facility will maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. These deficient practices resulted in Resident 11 experiencing severe sharp, stabbing pain in the arm and abdomen rated at 10/10 (approximately 48 hours), which required evaluation and treatment at a general acute care hospital (GACH). It also resulted in Resident 11 feeling very stressed, frustrated, and she described the pain as the worst pain she ever experienced.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included irritable bowel syndrome (a condition that affects a person's stomach and intestines and can cause abdominal cramping, bloating [uncomfortable feeling of fullness, tightness, or swelling in the abdomen] and change in bowel habits) alcoholic cirrhosis of liver (when long term alcohol use severely damage the liver causing it to harden) with ascites (accumulation of fluid in the abdomen), secondary esophageal varices (enlarged, fragile veins in the lower part of the throat at risk of bleeding) without bleeding , quadriplegia, (paralysis of both arms, and both legs), contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and cervical disc disorder (condition affecting the intervertebral discs in the cervical spine (neck region) with myelopathy (disorder or injury affecting the spinal cord) and spinal stenosis (condition where the spaces within a person's spine narrow).During a review of the Resident 11's Order Summary Report dated 6/9/25, the order indicated:-Monitor Resident 11 for pain (mild pain 1-4, moderate pain 5-7, severe pain 8-10) every shift-Acetaminophen oral tablet 325 milligrams (mg-unit of measurement), give two tablets by mouth every 6 hours as needed for mild pain of 1-4.-Document non-pharmacological interventions (repositioning, relaxation breathing, and massage) as needed and document results in the progress notes. During a review of Resident 11's Minimum Data Set (MDS- a resident's assessment tool) dated 6/14/2025, the MDS indicated Resident 11 had intact cognitive (ability to understand and be understood by others) skills for daily decision making. The MDS indicated Resident 11 was dependent (helper does all the effort. The resident makes no effort to complete the activity) with bed mobility, oral hygiene, toileting hygiene, personal hygiene, shower and upper/lower body dressing. During a review of Resident11's Order Summary Report dated 11/14/25, the order indicated (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	suboxone (medication used to control pain) sublingual (SL- under the tongue) film 2-0.5 mg, give one film SL one time a day for pain management. During a review of Resident 11's Pain Assessment, the record indicated:On 11/19/25 at 11:15p.m Resident 11's pain level was 7/10. On 11/21/25 at 4:42 a.m., Resident 11's pain level was 0/10. On 11/22/25 at 3:47 a.m., Resident 11's pain level was 0/10On 11/23/25 at 4:15 a.m. Resident 11's pain level was 0/10. On 11/23/25 at 7:35 p.m. Resident 11's pain level was 8/10. During a review of Resident 11's Pain Assessment the record indicated Resident 11's pain was not assessed on 11/21/25, after she complained of pain rated at 10/10 at 2:59 p.m., per RNS 3's progress notes.During a review of Resident11's Medication Administration Record (MAR) dated 11/19/2025, the MAR indicated Resident 11 received acetaminophen ([Tylenol] -pain relieving medication) oral tablet 325 mg, two tablets for a pain level of 7/10. During a review of Resident11's MAR dated 11/21/25 to 11/22/25, the MAR indicated Resident 11 did not receive suboxone, as ordered for pain management. During a review of Resident 11's Nurses Progress Note dated 11/21/25 at 2:59 p.m., the Nurses Progress Note indicated Resident 11 complained of severe pain 10/10 and had been vomiting for the last three days. During a review of Resident 11's Nurses Progress Note dated 11/21/25 at 4:59 p.m., the Nurses Progress Note indicated Resident 11 reported only her sublingual pain medication (unable to state the name) helped relief her pain. During a review of text message exchanges between RNS 3 and the NP dated 11/21/25 (unknown time), the text message indicated RNS 3 reported that Resident 11 had been vomiting for three days, complained of a sharp stubbing pain rated at 10/10 to her abdomen and arm. RNS 3 asked for options for Resident 1's pain of 10/10. The NP responded indicating for pain control use Tylenol suppository (medications you insert into patient's rectum [anal]) (if available), warm compress to the abdomen for comfort and reposition to reduce discomfort. During a review of text message exchanges between RNS 3 and the NP dated 11/22/25 at 1:35 p.m., the text messages indicated instructions from NP to transfer Resident 11 to the GACH immediately due to vomiting for three days, abdominal and arm pain rated 10/10, concerns for dehydration (body loses more fluid than it takes in) and possible esophageal varices. The NP indicated Resident 11 must be sent out to a GACH immediately for magnetic resonance imaging (MRI-a test that creates clear images of structures inside the body) and further evaluation. During a review of Nurse's Progress Note dated 11/23/25 at 5:50 p.m.,the Nurse's Progress Note indicated Resident 11 was transferred to a GACH due to esophageal pain rated at 10/10.During an interview on 11/5/2026 at 10:45 a.m., with Resident 11, Resident 11 stated, she was hospitalized on [DATE] for severe abdominal pain vomiting with blood that started on11/20/25. Resident 11 stated the pain was horrible, and nurses (unnamed) only gave her the lowest dose of Tylenol which could not help relieving her pain. Resident 11 stated she was very stressed, frustrated and had the worse abdominal pain. Resident 11 stated the SL medication was the only medication that relieved her pain, but nurses refused to give her for several days (11/14/25 to 11/16/25 and, 11/20/25 to 11/21/25). During an interview on 1/8/26 at 11:26 a.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated on 11/22/25 Resident 11 complained of severe pain in her abdomen and she notified a licensed nurse (name unknown).During a telephone interview on 1/8/25, at 12:03 p.m. with the NP, the NP stated on 11/21/25, staff were informed to monitor Resident 11's pain. The NP stated on 11/23/25, when Resident 11 complained of abdominal pain she decided it was no longer safe to keep Resident 11 in the facility, so she advised staff to send Resident 11 to the GACH for a Computed Tomography ([CT] process of taking pictures of the body, to diagnose diseases) scan for further evaluation. During an interview on 1/8/26 at 3:11p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, on 11/21/25, (unknown time) Resident 11 complained of abdominal pain, but he (LVN 3) did not assess the resident's pain location, level, or characteristic. LVN 3 stated he should have assessed Resident (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	11 for pain. LVN 3 stated he did not assess or record Resident 11's vital signs (VS-measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate) and pain scales were not recorded despite Resident 11 change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive behavioral, or functional status which without immediate intervention, may result in complications or death). LVN 3 stated Resident 11 should have been monitored at least every one to two hours after a COC. LVN 3 stated he notified RNS 2 that Resident 11 had severe abdominal pain, and the RNS 2 stated, what can we do. LVN 3 stated he did not document Resident 11's complaints of pain. During a concurrent interview and record review on 1/8/26 at 4:15 p.m., with RNS 3, Resident 11's Nurses Progress Notes 11/20/25 to 11/23/25, Pain Assessment for the month of 11/25, and MAR for the month 11/25, were reviewed. RNS 3 stated there was no documentation that Resident 11's pain assessment was done after the resident first complained of abdominal pain on 11/21/2025. RNS 3 stated Resident 11 was not provided pharmacological (medication) or non-pharmacological pain interventions on 11/21/25. RNS 3 stated on 11/21/25, Resident 11 complained of severe generalized pain rated at 10/10. RNS 3 stated she did not initiate a COC, administer any pain medication, provide non-pharmacological measures, assess or monitor Resident 11's pain when the resident complained. RNS 3 stated Resident 11 was not offered suboxone for pain relief because the medication was not available. RNS 3 stated she did not document the NP's text message order 11/21/25 to provide non-pharmacological interventions to the resident, in progress notes, or create a care plan to address Resident 11's pain, for continuity of care. RNS 3 stated failure to address Resident 11's pain could affect the resident mentally, physically, and potentially elevate the resident's blood pressure. During a review of the facility's P&P titled Pain Management dated 8/25/21, the P&P indicated To maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. The P&P indicated If the nursing assessment indicates pain: 1. Review care plan triggers.2. The nurse will notify the physician/advance practice provider as appropriate and obtain treatment orders as indicated.3. An individualized, interdisciplinary (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) care plan will be developed.4. Resident receiving interventions for pain will be monitor for the effectiveness and side effects.in providing pain relief. Document non-pharmacological interventions and effectiveness, effectiveness of as needed medications (PRN), ineffectiveness of routine or PRN medications including interventions, follow up, and physician notification. During a review of the facility's P&P titled, Charting and Documentation dated 7/2017, the P&P indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated the following information should be documented in the resident's medical record: a. Objective observationsb. Medications administeredc. Treatments or services performedd. Changes in the residents' conditione. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure timely completion of STAT (immediately) laboratory tests for one of two sampled residents (Resident 11) as ordered by the Nurse Practitioner on 11/22/25 at 7:13 p.m., without waiting until 11/23/25 at 8:00 a.m., (approximately 13 hours) after the orders were received. This failure had the potential to negatively impact Resident 11's health by delaying critical diagnostic information necessary for timely treatment decisions, increasing the risk of the resident's condition worsening, leading to complications, and compromising the overall quality of care.Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included irritable bowel syndrome (a condition that affects a person's stomach and intestines and can cause abdominal cramping, bloating [uncomfortable feeling of fullness, tightness, or swelling in the abdomen] and change in bowel habits) alcoholic cirrhosis of liver (when long term alcohol use severely damage the liver causing it to harden) with ascites (accumulation of fluid in the abdomen), secondary esophageal varices without bleeding , quadriplegia, (paralysis of both arms, and both legs), contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and cervical disc disorder (condition affecting the intervertebral discs in the cervical spine (neck region) with myelopathy (disorder or injury affecting the spinal cord) and spinal stenosis (condition where the spaces within a person's spine narrow). During a review of Resident 11's Minimum Data Set (MDS- a resident's assessment tool) dated 6/14/2025, the MDS indicated Resident 11 had intact cognitive (ability to understand and be understood by others) skills for daily decision making. The MDS indicated Resident 11 was dependent (helper does all the effort and the resident makes none of the effort to complete the activity) with bed mobility, oral hygiene, toileting hygiene, personal hygiene, shower and upper/lower body dressing. During a review of Resident 11's Physician Order dated 11/22/25 at 5:40 p.m., the Physician Order indicated a STATE order for Complete Blood Count (CBC) - blood test that measures several components of the resident's blood) , Comprehensive Metabolic Profile ([CMP] - blood test that measures 14 different substances to evaluate the body's chemical balance, Lipase (blood test) and Lactate (blood test) as ordered. During a review of text message exchanges between RNS 3 and the NP dated 11/22/25 at 6:06 p.m., Nurse Practitioner (NP) asked Registered Nurse Supervisor (RNS) 3 if Resident 11 was transferred to general acute care hospital (GACH). RNS 3 responded that the RN Supervisor (name unknown) from 7 a.m. to 3 p.m., shift told her the Director of Nursing (DON) advised not to take Resident 11 to the GACH, to start intravenous (IV-through the vein) fluids and STAT (immediately) labs. RNS 3's text message also indicated Resident 11 had vomiting with pain and abdominal discomfort. NP responded to continue IV hydration and complete the STAT Complete Blood Count (CBC) - blood test that measures several components of the resident's blood) , Comprehensive Metabolic Profile ([CMP] - blood test that measures 14 different substances to evaluate the body's chemical balance, Lipase (blood test) and Lactate (blood test) as ordered. During a concurrent interview and record review on 11/8/26 at 4:15 p.m., with RNS 3, Resident 11's Physician Orders dated 11/22/25 and lab results dated 11/23/25 were reviewed. RNS 3 stated lab tests were not performed until 11/23/25 at 8:00 a.m. (13 hours after the orders received). RNS 3 stated STAT lab orders were supposed to be completed within four hours, RNS 3 stated she was unsure why Resident 11's lab draw was delayed. During a review of Resident 11's lab result dated 11/23/25, the lab result indicated collection date of 11/23/25 at 8:00 a.m., received 11/23/25 at 10:35a.m., and reported 11/23/25 at 12:50 p.m.During a review of the (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy and procedure (P&P) titled Laboratory Services undated, the P&P indicated When there is a STAT order for laboratory testing, facility must call in the order to the laboratory immediately, upon getting the order from the physician. Please identify the order as a STAT order. The facility will make its best efforts to limit STAT orders for critical conditions, as deemed absolutely necessary by the physician.The nursing staff must completely fill out a requisition and place it in the laboratory binder. Nurse must clearly mark STAT on the requisition form for expedited processing. Laboratory will send a phlebotomist to collect specimens, arrange for transportation to a laboratory for testing and results.Laboratory will prioritize and expedite all qualified stat orders. It is our goal to complete STAT orders promptly within a 4-to-6-hour timeframe. Results are automatically faxed to the facility fax number and uploaded in EMR (electronic medical record) as appropriate. Cross reference F684