

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269</p> <p>Based on observation, interview, and record review the facility failed to maintain respect and dignity to one of three sampled residents (Resident 57) by standing over the resident while assisting them during a meal.</p> <p>This failure had the potential to result in decreased self-esteem and self-worth for Resident 57.</p> <p>Findings:</p> <p>During a review of Resident 57's Admission Record, the Admission Record indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including unspecified dementia(a progressive state of decline in mental abilities) without behavioral disturbance, cerebral infarction without residual effects (stroke without lasting impairments or resident had recovered after the event), and oropharyngeal dysphagia (difficulty of swallowing that occurs when the food or liquid is moved from the mouth to the esophagus).</p> <p>During a review of Resident 57's Minimum Data Set (MDS- a resident assessment tool) dated 8/6/2024, the MDS indicated Resident 57 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) and required substantial assistance (helper does more than half the effort) with eating.</p> <p>During an observation on 11/12/2024, at 12:44 p.m., in Resident 57's room, Resident 57 was lying in bed in an upright position and Certified Nursing Assistant (CNA1) standing over the resident while feeding her lunch.</p> <p>During an interview on 11/13/2024, at 2:59 p.m., with CNA1, CNA1 stated she was standing while feeding Resident 57 during lunch yesterday (11/12/2024). CNA1 stated she should have gotten a chair and sit down while feeding Resident 57 because for her comfort and resident's safety. CNA1 stated feeding the resident in a sitting position should have been done so she would be in level to resident's mouth and ensure resident's needs would be anticipated.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024, at 3:09 p.m., with Director of Staff Development (DSD), DSD stated the facility provided training on activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care, how to transfer, feeding residents, incontinence care (process of helping someone maintain or regain of their bladder and bowel functions), and repositioning during CNA's orientation. DSD stated CNA 1 needed to sit down and should be within eye level so she could see signs and symptoms of aspiration (happens when food, liquid, or other material breathed into the lungs). DSD stated sitting down to be within eyelevel of the resident was important for resident's safety and maintaining their dignity.</p> <p>During an interview on 11/15/2024, at 2:55 p.m. with the Director of Nursing (DON), the DON stated whoever was feeding the resident, should be sitting in a chair to maintain resident's dignity and to ensure the resident was not aspirating the food.</p> <p>During a review of facility's policy and procedure (P&P) titled Dignity revised 12/2021, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being and feelings of self-worth and self-esteem. The P&P indicated the residents will be provided with a dignified dining experience while assisting with their care.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269</p> <p>Based on observation, interview, and record review, the facility failed to accommodate the individual needs and preferences of two of 21 sampled residents (Resident 37 and Resident 179) by failing to:</p> <p>a. Address Resident 37's concern regarding insufficient space of his room which prevented him to move around comfortably and access his closet and wheelchair easily due to limited space.</p> <p>b. Address Resident 179's concern about the noise coming from resident's roommate which affected his sleep.</p> <p>These failures had the potential to affect Resident 37's and Resident 179's health, psychosocial wellbeing and safety.</p> <p>Findings:</p> <p>During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (a condition in which there are high levels of fat in the blood), and hydronephrosis with renal and ureteral calculous obstruction(a condition where one or both kidneys swell due to a blockage in the urinary tract that prevents urine from draining properly).</p> <p>During a review of Resident 37's Minimum Data Set (MDS resident assessment tool) dated 10/24/2024, the MDS indicated Resident 37 had an intact cognition (ability to think, understand, learn, and remember) and required supervision or touching assistance (helper provides verbal cues or touching / steadying as resident complete the activity) with chair/bed-to-chair transfer, toilet transfer and walking. The MDS indicated Resident 37 used wheelchair and walker as mobility devices.</p> <p>During a review of Resident 37's History and Physical (H&P) dated 9/6/2024, the H&P indicated Resident 37 had the capacity to understand and make decisions.</p> <p>During a concurrent observation and interview on 11/12/2024, at 3:32 p.m., in Resident 37's room, Resident 37's bed was near the closet area with a small space in between the closet and resident's bed. Resident 37 stated he hated the small living space of the room because it affected his mobility especially when the staff member would provide care to his roommate because they would occupy the space where his wheelchair was located causing him to be moved to the side of the bed. Resident 37 stated he could not get into his closet easily because of the small space in between the bed and closet and he was not offered a room change for his concern. Resident 37 stated he would not be able to get out of his room easily if there was an emergency in the facility.</p> <p>During a concurrent observation and interview on 11/14/2024 with Maintenance Supervisor (MS), observed MS measured the room of Resident 37 and his roommate. MS stated it was 154 square feet of the room with two residents inside. MS stated Resident 37 had lots of things in his room and he was aware the room did not have enough space.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024, at 2:55 p.m. with the Director of Nursing (DON), the DON stated having an insufficient living space could lead to accident and will cause inconvenience to the resident.</p> <p>b. During a review of Resident 179's Admission Record, the Admission Record indicated Resident 179 was admitted to the facility on [DATE] with diagnoses including heart failure (serious condition that occurs when the heart cannot pump enough blood and oxygen to the body's organs), weakness, angina pectoris(chest pain or discomfort that occurs when the heart muscle does not receive enough blood and oxygen), and acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood).</p> <p>During an interview on 11/12/2024, at 9:44 a.m., and subsequent interview on 11/14/2024, at 3:45 p.m. with Resident 179, Resident 179 stated he was feeling tired and could not sleep at night because his roommate would scream and talked loudly at night. Resident 179 stated he told an unnamed staff member this morning (11/14/2024) and another staff yesterday (11/13/2024) for a room change.</p> <p>During an observation on 11/14/2024, at 3:49 p.m., Resident 179's roommate was lying in bed and screaming and calling someone's name.</p> <p>During an interview on 11/14/2024, at 4:08 p.m., with Certified Nursing Assistant (CNA 2), CNA 2 stated Resident 179 was complaining about the noise coming from his roommate and requested to get a room change. CNA 2 stated he told his charge nurse yesterday (11/13/2024).</p> <p>During an interview on 11/15/2024, at 12:08 p.m., with Case Manager (CM), CM stated she was aware Resident 179 was complaining of the noise level coming from his roommate and this was communicated to Social Service Director (SSD) on 11/13/2024 Interdisciplinary Team Meeting (IDT- a gathering of various healthcare professionals to coordinate care for a resident). CM stated the noise coming from his roommate will affect Resident 179's sleep at night and could affect his health and should be addressed right away.</p> <p>During a review of Resident 179's IDT Care Conference dated 11/13/2024, the IDT Care Conference indicated resident's concern for inability to sleep at night due to noise was not addressed in the meeting.</p> <p>During an interview on 11/15/2024, at 12:22 p.m., with SSD, SSD stated she knew Resident 179's concern about the noise at night which preventing Resident 179 to get some sleep. SSD stated Resident 179 was not transferred right away because of the room availability. SSD stated Resident 179 lack of sleep could have an effect on his psychosocial being which could prevent him not doing any activities due to fatigue.</p> <p>During a review of facility's census for 11/14/2024, the facility's census indicated 11 empty beds.</p> <p>During a review of facility's census for 11/13/2024, the facility's census indicated 13 empty beds.</p> <p>During an interview on 11/15/2024, at 2:55 p.m. with the DON, the DON stated inability to get sleep due to noise level could affect Resident 179's health and psychosocial being.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility's policy and procedure (P&P) titled' Accommodation of Needs undated, the P&P indicated in order to accommodate individual needs and preferences, adaptations may be made in their physical environment to maintain and achieve safe, independent functioning, dignity, and well-being.</p> <p>During a review of facility's P&P titled Homelike Environment undated, the P&P indicated the facility staff will provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences, The P&P indicated the facility staff and management will maximize to the extent possible the characteristics of the facility that reflect a personalized , homelike setting that include comfortable sound levels, clean, orderly environment and personalized furniture and room arrangements.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to ensure three of 45 sampled residents (Resident 6, 17, and 34), were provided privacy curtains to completely cover the residents during care.</p> <p>This failure prevented Resident 6, 17, and 34 from having complete privacy during care and had the potential to affect their dignity and self-worth.</p> <p>Findings:</p> <p>a. During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area), dysphagia (difficulty swallowing) affecting the left non-dominant side, and contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the left leg.</p> <p>During a review of Resident 34's Care Plan titled Incontinence (involuntary loss of bladder or bowel control), initiated 11/15/2023, the interventions indicated to provide Resident 34 with privacy and comfort.</p> <p>During a review of review of Resident 34's Minimum Data Set ([MDS] a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 34 had clear speech, understood verbal content, expressed ideas, and wants, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 34 had range of motion ([ROM] full movement potential of a joint [where two bones meet]) limitations in one arm and both legs. The MDS further indicated Resident 34 required partial/moderate assistance (helper does less than half the effort) for upper body dressing and rolling to both sides while lying in bed and required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and toileting.</p> <p>During an observation on 11/13/2024 at 8:46 a.m. with Restorative Nursing Aide 1 (RNA 1) and RNA 2, the door of Resident 34's room was closed. RNA 1 and RNA 2 entered Resident 34's room. Resident 34's privacy curtain was pulled on the left side of the bed in-between Resident 34 and Resident 34's roommate (Bed B). There was no privacy curtain observed on the right side of Resident 34's bed. Resident 34 was visibly turned to the right side while Certified Nursing Assistant 3 (CNA 3) stood on the right side of the bed holding an incontinence brief. Resident 34 was observed waving the right arm in a shooing away motion. CNA 3 stated Resident 34 wanted privacy since the curtain did not cover the right side of Resident 34's bed.</p> <p>During an interview on 11/13/2024 at 9:41 a.m., CNA 3 stated Resident 34's curtain was not wide enough to provide Resident 34 with full privacy. CNA 3 pulled the curtain between Resident 34 and Bed B and then closed the door for privacy.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/13/2024 at 11:44 a.m., CNA 3 stated she had to choose which side of Resident 34's bed to cover. CNA 3 stated ideally the privacy curtain should be fully closed to prevent Resident 34 from being visible from the door and Resident 34's roommates. CNA 3 stated she would feel embarrassed if someone walked into the room while CNA 3 was getting dressed.</p> <p>b. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), dementia (a progressive state of decline in mental abilities), dysphagia, contracture of muscles in both lower legs, and stiffness in the left shoulder, right elbow, wrist (unspecified), and right hand.</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 5 did not have any speech, was never/rarely understood, never/rarely understood others, and was severely impaired for daily decision making. The MDS indicated Resident 6 had ROM limitations in both arms and legs and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for toileting, showering, dressing, personal hygiene, rolling to either side in bed, and chair/bed-to-chair transfers.</p> <p>During an observation on 11/13/2024 at 9:13 a.m., RNA 1 went into Resident 6's room to assist Certified Nursing Assistant 4 (CNA 4) with Resident 6's care.</p> <p>During a concurrent observation and interview on 11/13/2024 at 9:15 a.m., in Resident 6's room with CNA 4, RNA 1, and RNA 2, Resident 6's privacy curtain covered the left of Resident 6's bed upon entering the room. There was no privacy curtain observed on the right side of Resident 6's bed in-between Resident 6 and Resident 6's roommate. CNA 4 pulled Resident 6's curtain between the beds, which caused the curtain to pull away from the left side of Resident 6's bed near the entrance door. RNA 2 stated Resident 6's curtain did not provide Resident 6 with full privacy around the entire bed.</p> <p>During an interview on 11/13/2024 at 9:21 a.m., CNA 4 stated he was giving Resident 6 a bed bath. CNA 4 stated the privacy curtain was not pulled between Resident 6 and Resident 6's roommate.</p> <p>During an interview on 11/13/2024 at 11:44 a.m., CNA 4 stated Resident 6 was dependent on staff for assistance. CNA 4 stated he would feel embarrassed if the privacy curtain was not closed completely while being undressed.</p> <p>c. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses included cerebral infarction, aphasia (loss of ability to understand or express speech as a result of brain damage) following a cerebral infarction, hemiparesis affecting right dominant side, and acquired absence of the left leg above the knee.</p> <p>During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 did not have any speech, rarely/never understood others, rarely/never expressed ideas, and wants, and was severely impaired for daily decision making. The MDS indicated Resident 17 had ROM limitations in one arm and one leg. The MDS also indicated Resident 17 was dependent with toileting, dressing, lying to sitting on the side of the bed, and chair/bed-to-chair transfer.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 11/13/2024 at 9:48 a.m. in Resident 17's room with RNA 1 and RNA 2, RNA 2 pulled the curtain on the right side of Resident 17's bed in-between Resident 17 and Resident 17's roommate prior to performing exercises with Resident 17. There was no curtain observed on the left side of Resident 17's bed. RNA 2 stated the curtain did not fully cover around Resident 17's bed which was a privacy issue. RNA 2 stated Resident 17's door needed to be closed for privacy and proceeded to close the door.</p> <p>During an interview on 11/15/2024 at 12:04 p.m. with the Administrator (ADM), the Environmental Services Supervisor (ESS), and the Environmental Services Regional Consultant (ESRC), the ADM stated the facility was in the process of renovating the facility's public spaces. The ADM stated the residents' rooms will be the next renovation project, which included the privacy curtains. The ADM stated she would feel not great if someone walked in while the ADM was getting dressed.</p> <p>During an interview on 11/15/2024 at 12:21 p.m. with the Director of Nursing (DON), the DON stated the residents (in general) should be covered completely while providing care for the resident's privacy and dignity.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated the facility staff promoted, maintained, and protected resident privacy, including bodily privacy during assistance with personal care and during treatment.</p> <p>During a review of the facility's P&P titled, Confidentiality of Information and Personal Privacy, revised 10/2017, indicated the facility will strive to protect the resident's privacy during personal care.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>49145</p> <p>Based on interview and record review, the facility failed to ensure a change of condition (COC), was completed when Resident 30 developed a urinary tract infection ([UTI]- an infection in any part of the urinary system).</p> <p>This failure had the potential to result in the inability to determine the improvement or worsening of the infection leading to Resident 30 not receiving the appropriate care.</p> <p>Findings:</p> <p>During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility 6/4/2021 with diagnoses including obstructive uropathy (urine cannot drain through the urinary tract) and benign prostatic hyperplasia ([BPH]- enlarged prostate).</p> <p>During a review of Resident 30's Minimum Data Set ([MDS]- a resident assessment tool) dated 9/29/2024, the MDS indicated Resident 30's has intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 30 required partial/moderate assistance (helper does less than half the effort) with toileting, bathing, and dressing.</p> <p>During a review of Resident 30's Medication Administration Record (MAR), the MAR indicated Bactrim (medication used to treat infections) was administered to Resident 30 for a UTI times seven days beginning on 11/7/2024.</p> <p>During a concurrent interview and record review on 11/15/2024 at 9:03 a.m., with the Infection Prevention Nurse (IPN), the IPN stated a COC represents a change from a resident's baseline, such as a UTI, and was a form of communication between the staff. IPN stated there was no COC for Resident 30's UTI on 11/7/2024 but there should be, so the staff were aware of what was going on with the resident.</p> <p>During a concurrent interview and record review on 11/15/2024 at 10:38 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated a COC should be done when there was a change in condition, such as a UTI. LVN 1 stated there was no COC form done for Resident 30's UTI on 11/7/2024. LVN 1 stated there should be a COC so the staff can monitor his UTI for improvement.</p> <p>During a concurrent interview and record review on 11/15/2024 at 3:30 p.m., with the Director of Nursing (DON), the DON stated there was no COC for Resident 30's UTI but should have been so the staff can better monitor the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, undated, the P&P indicated, Licensed nurses are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Nursing Documentation, dated 6/27/2022, the P&P indicated the purpose, To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's condition, situation, and complexity.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145</p> <p>Based on interview and record review, the facility failed to accurately complete a Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) I for one of three sampled residents (Resident's 18).</p> <p>This failure had the potential to result in an inappropriate placement and delay of needed services for Resident's 18.</p> <p>Findings:</p> <p>During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy).</p> <p>During a review of Resident 18's Minimum Data Set ([MDS]- a resident assessment tool) dated 8/15/2024, the MDS indicated Resident 18 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 18 was dependent with toileting, bathing, eating, and dressing.</p> <p>During a review of Resident 18's History and Physical (H&P) dated 1/17/2024, the H&P indicated a diagnosis of paranoid schizophrenia.</p> <p>During a review of Resident 18's care plan titled Schizoaffective disorder manifested by auditory hallucinations (hearing sounds or voices that aren't actually there) and talking to someone non-existent initiated on 2/17/2022, the Care Plan interventions for Resident 18 included monitoring medications for side effects and resident's/patient's response contributing to verbal behaviors.</p> <p>During a review of Resident 18's Medication Administration Record (MAR), dated 1/1/2024-2/31/2024, the MAR indicated Resident 18 was receiving Seroquel (an anti-psychotic medication that treats several kinds of mental health conditions including schizophrenia).</p> <p>During a review of Resident 18's PASARR I, dated 1/17/2024, the PASARR I indicated a negative Level I am screening. The PASARR I indicated Resident 18 did not have a serious diagnosis of mental disorder (conditions that affect your thinking, feeling, mood, and behavior) and was not prescribed psychotropic medications (medications that affect the mind, emotions, and behaviors) for mental illness.</p> <p>During a concurrent interview and record review on 11/15/2024 at 11:46 a.m., with the Director of Nursing (DON), the DON stated he was responsible for ensuring the PASARR was completed and accurate. The DON stated Resident 18 has a diagnosis of paranoid schizophrenia and is currently taking Seroquel. The DON stated Resident 18's PASARR was inaccurate, and this could cause a delay in services.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	
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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, PASARR Completion Policy, undated, the P&P indicated, The Center will make sure all admissions have the appropriate PASARR completed, and the facility will follow state-specific guidelines for completion.</p> <p>45269</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to revise the care plans for two of four sampled residents (Resident 6 and 20) with limitation in range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns by failing to:</p> <p>a. Revise Resident 6's care plans and conduct an Interdisciplinary Team ([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) conference with the resident's representative after discharge from hospice care (specialized care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort, quality of life rather than cure, and free of pain to live each day as fully as possible) on 1/13/2024.</p> <p>b. Revise Resident 20's care plan for Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) after passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) exercises for the left leg and application of the left knee splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) was discontinued on 9/13/2024.</p> <p>These failures resulted in Resident 6 not receiving any intervention to address ROM limitations from 1/13/2024 to 3/5/2024 and had the potential to affect Resident 20's provision of care.</p> <p>Findings:</p> <p>a. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of muscles in both lower legs, and stiffness in the left shoulder, right elbow, wrist (unspecified), and right hand.</p> <p>During a review of Resident 6's Physician Orders, dated 1/13/2024, the Physician Orders indicated to transfer Resident 6 to custodial care (care with activities of daily living [ADLs] related to personal care including bathing, dressing, hygiene, eating, and mobility) from hospice care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), dated 1/16/2024, the MDS indicated Resident 6 had a significant change in status. The MDS indicated Resident 6 did not have any speech, was never/rarely understood, never/rarely understood others, and was severely impaired for daily decision making. The MDS indicated Resident 6 had ROM limitations in both arms and legs and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for toileting, showering, dressing, personal hygiene, rolling to either side in bed, and chair/bed-to-chair transfers. Resident 6's MDS was signed as complete on 1/30/2024.</p> <p>During a review of Resident 6's care plan review for the significant change in status, the care plan review began on 2/13/2024 and was completed on 3/12/2024.</p> <p>During a review of Resident 6's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation, dated 3/5/2024, the OT Evaluation indicated Resident 6 had rigid muscle tone and ROM impairments in both arms, including ROM limitation in both shoulders, both elbows, the left wrist, and the right hand.</p> <p>During a review of Resident 6's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 3/9/2024, the PT Evaluation indicated Resident 6 had ROM impairments in both legs, including ROM limitations in both knees and longstanding plantarflexion (ankle bent with toes pointing away from the body) contractures in both ankles.</p> <p>During a review of Resident 6's OT Discharge Summary, dated 4/22/2024, the OT Discharge Summary indicated the RNA (unknown) was trained and provided a good return demonstration of PROM exercises to both arms and application of both arm splints to maintain Resident 6's current ROM and to prevent further contractures.</p> <p>During a review of Resident 6's PT Discharge Summary, dated 4/25/2024, the PT Discharge Summary indicated the RNA (unknown) was instructed on proper handling during PROM to maintain Resident 6's ROM. The PT Recommendations included an RNA program (unspecified).</p> <p>During a review of Resident 6's Physician Orders, dated 4/25/2024, the Physician Order indicated for the RNA to perform PROM on both legs, five times per week as tolerated. Resident 6's Physician Orders, dated 5/2/2024, also indicated for the RNA to provide Resident 6 with PROM on both arms, application of the right resting hand splint for four hours, and application of both elbow splints for four hours, five times per week as tolerated.</p> <p>During a review of Resident 6's care plan titled, Restorative Range of Motion (ROM), initiated 4/25/2024, the care plan indicated the RNA would provide PROM to both arms and legs, five times per week as tolerated.</p> <p>During a review of Resident 6's care plan titled, Restorative splinting and/or brace, initiated 7/11/2024, indicated the RNA would apply Resident 6's right resting hand splint and both elbow splints for four hours, five times per week as tolerated with skin checks.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 11/13/2024 at 9:22 a.m., in Resident 6's room, Resident 6's RNA session was observed. Resident 6 was lying in bed with both shoulders internally rotated (rotated toward the body) and both elbows bent more than 90 degrees, which caused both arms to cross over Resident 6's chest. Restorative Nursing Aide 1 (RNA 1) stood on the left side of Resident 6's bed while RNA 2 stood on the right side of the bed. RNA 2 performed PROM to Resident 6's right arm and applied the right elbow splint. RNA 1 performed PROM to Resident 6's left arm and applied the left elbow splint. RNA 1 stated the right-hand splint had to be cleaned prior to applying to Resident 6's right hand.</p> <p>During a concurrent interview and record review on 11/14/2024 at 12:34 p.m. with the Director of Rehabilitation (DOR), Resident 6's MDS, dated [DATE], was reviewed. The DOR stated Resident 6's MDS was a significant change of condition since Resident 6 was discharged from hospice care on 1/13/2024. The DOR stated the MDS indicated Resident 6 had ROM impairments to both arms and legs. The DOR stated PT and OT were not notified of Resident 6's significant change of condition on 1/13/2024. The DOR stated Resident 6 did not receive any intervention from PT and OT for ROM impairments until the OT Evaluation, dated 3/5/2024.</p> <p>During an interview on 11/14/2024 at 4:22 p.m. with the MDS Coordinator (MDSC), the MDSC stated comprehensive MDS assessments included the admission, annual, and significant change of status. The MDSC stated the care plans (in general) identified and included interventions for a resident's problems or preferences. The MDSC stated a resident's care plan conference (in general) was completed within the week of completing the MDS to keep the resident and family updated regarding the resident's care plan.</p> <p>During a concurrent interview and record review on 11/14/2024 at 4:41 p.m. with the MDSC, Resident 6's MDS, dated [DATE], and IDT notes were reviewed. The MDSC stated Resident 6's significant change of status assessment was completed on 1/16/2024 due to the resident's discharge from hospice care on 1/13/2024. The MDSC stated the MDS indicated Resident 6 had impairments to both arms and both legs. The MDSC reviewed the IDT notes and assessments. The MDSC was unable to locate any IDT notes for Resident 6's significant change of condition. The MDSC stated the IDT should have met with the resident or representative either the week of or the week after Resident 6's significant change assessment (1/13/2024).</p> <p>During a concurrent interview and record review on 11/15/2024 at 12:50 p.m. with the MDSC, Resident 6's care plans were reviewed. The MDSC reviewed all of Resident 6's care plans and was unable to locate any care plans and interventions for Resident 6's ROM limitations from 1/13/2024 (discharge from hospice) to 3/5/2024 (OT Evaluation). The MDSC stated Resident 6's MDS, dated [DATE], was completed on 1/30/2024. The MDSC stated Resident 6's care plans should have been reviewed seven days after the completion of the MDS on 1/30/2024. The MDSC stated Resident 6's care plan review was started late on 2/13/2024 and was completed late on 3/22/2024.</p> <p>During an interview on 11/15/2024 at 1:42 p.m. with the Director of Nursing (DON), the DON stated care plans identified a resident's problems and the interventions for the problem. The DON stated the resident's needs (in general) may not be met if the care plans were not revised.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebrovascular disease (loss of blood flow to the brain) affecting the left non-dominant side, contracture of the left lower leg, and acquired absence of the right leg above the knee.</p> <p>During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had clear speech, understood verbal content, expressed ideas, and wants, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 20 had ROM limitations in one arm and both legs.</p> <p>During a review of Resident 20's Physician Orders, dated 2/16/2024, the Physician Orders indicated for the RNA to provide PROM to the left arm, five times per week, and application of the left resting hand splint for four hours, five times per week. Resident 20's Physician Orders, dated 2/19/2024, for RNA to provide PROM to the left leg and application of the left knee splint, five times per week, was discontinued on 9/13/2024.</p> <p>During a review of Resident 20's care plan titled, Restorative Range of Motion (ROM), initiated 2/19/2024, the care plan interventions included for the RNA to provide PROM to the left arm and left leg, five times per week as tolerated. The care plan also included for the RNA to apply a left resting hand splint and the left knee splint for four hours, five times per week.</p> <p>During an interview on 11/13/2024 at 10:10 a.m., with Restorative Nursing Aide 1 (RNA 1), RNA 1 stated Resident 20 received RNA for PROM to the left arm and application of the left-hand splint. RNA 1 stated Resident 20 received PT services for the left leg and application of the left knee splint.</p> <p>During an observation on 11/13/2024 at 10:13 a.m., in Resident 20's room with RNA 1, Resident 20's RNA session was observed. RNA 1 provided PROM to the left arm and applied the left-hand splint.</p> <p>During an observation on 11/13/2024 at 2:19 p.m., in Resident 20's room with Physical Therapist Assistant 1 (PTA 1), Resident 20's PT session was observed. PTA 1 provided manual therapy (skilled hand movements to treatment pain and disability) to Resident 20's left leg and applied the left knee splint.</p> <p>During a concurrent interview and record review on 11/14/2024 at 4:29 p.m., with the MDSC, Resident 20's Restorative (RNA) ROM care plans were reviewed. The MDSC stated Resident 20's care plan included PROM for the left arm and left leg, application of the left-hand splint, and application of the left knee splint. The MDSC stated the Physician Orders for RNA to provide PROM to the left leg and application of the left knee splint was discontinued on 9/13/2024. The MDSC stated the care plan should have been revised when the Physician Orders were discontinued.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the facility's IDT in coordination with the resident, family, and/or representative must develop and implement a comprehensive person-centered care plan for each resident, including when there was a significant change in the resident's condition. The P&P indicated the comprehensive care plan would be developed within seven days of the resident's MDS completion and would include services provided to attain or maintain a resident's physical well-being.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269</p> <p>Based on interview and record review, the facility failed to provide the necessary services and care to two of four sampled residents (Resident 18 and Resident 45) by failing to:</p> <p>a.Ensure Resident 18 was provided the necessary medications for constipation (a condition in which stool becomes hard, dry, difficult to pass and bowel movements become infrequent) when the resident had no bowel movement (movement of feces through the bowel and out the anus) for five days.</p> <p>b. Monitor occurrence of bowel movement for Resident 45 and provide necessary medications for constipation as ordered by the physician.</p> <p>These failures had the potential to put Resident 18 and Resident 45 at risk for fecal impaction (hardened stool that's stuck in the rectum or lower colon) that could lead to bowel obstruction (partial or complete blockage of small or large intestines which is life threatening).</p> <p>Findings:</p> <p>a.During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including dementia (the loss of cognitive functioning- thinking, remembering, and reasoning- to such an extent that it interferes with a person's daily life and activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) .</p> <p>During a review of Resident 18's Minimum Data Set ([MDS] resident assessment tool) dated 8/15/2024, the MDS indicated Resident 18 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 18 was dependent with eating, toileting, dressing, and bathing.</p> <p>During a review of Resident 18's Care Plan titled Resident 18 was at risk for gastrointestinal (the organs and system that digest and move food and liquids through the body) complications related to constipation initiated 11/29/2020, the care plan with goals included Resident 18 to not develop any gastrointestinal complications. The Care Plan interventions for Resident 18 included to monitor and record bowel movements, provide bowel regimen, and to assess for signs and symptoms of constipation.</p> <p>During a review of Resident 18's Physician Order Summary Report, the Physician Order Summary Report indicated an order was placed on 1/16/2024 for MiraLAX Powder (medication to prevent and treat occasional constipation) to be given as needed if resident has not had a bowel movement in the past 72 hours.</p> <p>During a review of Resident 18's Activities of Daily Living (ADL) Task screen, the ADL toileting task indicated Resident 18 had not had a bowel movement from 11/9/2024 to 11/14/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/14/2024 at 12:31 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 18's last bowel movement was 11/8/2024 and no medications were administered to Resident 18 for his constipation. LVN 2 stated if a resident does not have a bowel movement in three days, the resident needs to be given a laxative (a medication that helps you have a bowel movement when you're constipated). LVN 2 stated Resident 18 should have received MiraLAX because she had not had a bowel movement in over three days, and this could result in Resident 18 experiencing nausea, vomiting, and bowel obstruction.</p> <p>During a concurrent interview and record review on 11/14/2024 at 2:12 p.m., with the Director of Nursing (DON), the DON stated Resident 18 could develop a bowel obstruction because she has not had a bowel movement for several days. The DON stated their policy was to give a laxative if a resident does not have a bowel movement in three days.</p> <p>During an interview on 11/14/2024 at 2:40 p.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated if a resident does not have a bowel movement for three days, he informs the charge nurse immediately. CNA 4 stated the resident not having a bowel movement for three days could cause the resident to not feel well or not eat.</p> <p>During an interview on 11/15/2024, at 1:30 p.m. with Director of Staff Development (DSD), DSD stated licensed nurses were responsible to know if the resident was having constipation. DSD stated CNAs should notify the charge nurse for any missed bowel movement because the residents are on medications that can be given for constipation. DSD stated residents should be monitored for constipation or occurrences of bowel movement because the resident could have a change of condition like vomiting, and abdominal pain which could lead to bowel obstruction.</p> <p>49145</p> <p>b. During a review of Resident 45's Admission Record, the Admission record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (progressive state of decline in mental abilities), difficulty of walking, major depressive disorder (mental health condition with persistent low mood and loss of interest in activities that were once enjoyable), and benign prostatic hyperplasia (BPH-enlargement of the prostate gland).</p> <p>During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 had severe cognitive impairment The MDS indicated Resident 45 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, dressing and bathing.</p> <p>During a review of Resident 45's Activity of Daily Living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Task for toileting for the month of October 2024, the ADL Task for toileting indicated Resident 45 had no bowel movement from 10/26/2024, 10/27/2024, 10/28/2024, 10/29/2024 and 10/30/2024.</p> <p>During a review of Resident 45's Medication Administration Record (MAR) dated 10/26/2024 to 10/31/2024, the MAR indicated Milk of Magnesia (MOM- medicine to treat constipation, upset stomach or heartburn), Dulcolax suppository (medication to treat constipation) or fleets enema (a saline laxative used to relieve constipation and clean the intestines) were administered to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 45's Physician Order Summary Report, the Physician Order Summary report dated 10/4/2024 indicated an order of milk of magnesia 400 milligrams (mgs. - unit of measurement) give 30 milliliters (ml- unit of measurement) every 24 hours as needed for constipation if no bowel movement in 3 days.</p> <p>During a review of Resident 45's Physician Order Summary Report dated 10/4/2024, the Physician Order Summary Report indicated an order for Dulcolax suppository 10 mgs. insert one suppository rectally every 24 hours as needed for constipation if no result from milk of magnesia.</p> <p>During a review of Resident 45's Physician Order Summary Report dated 10/4/2024, the Physician Order Summary Report indicated to monitor side effects of anti-psychotic medicines (medicines that work by altering brain chemistry to help reduce symptoms like hallucinations [perception that seem real but are not], delusions { a fixed false belief that a person holds onto, even when presented with evidence that it is not true} and disorganized thinking) related to Seroquel (medicine used to treat depression) like dry mouth, constipation, blurry vision confusion involuntary and loss of appetite.</p> <p>During a review of Resident 45's Care Plan titled Resident is at risk for gastrointestinal symptoms or complications related to history of constipation initiated 10/4/2024, the Care Plan goals indicated Resident 45 will not develop gastrointestinal complications for 90 days. The Care Plan interventions included monitoring, recording of bowel movements and providing bowel regimen (set of medications to help residents avoid or relieve constipation), utilize pharmacologic agents (medicines) as appropriate like stool softeners, laxative and document effectiveness.</p> <p>During a concurrent interview and record review on 11/15/2024, at 1:30 p.m. with Certified Nursing Assistant (CNA 2), reviewed Resident 45 's ADL Task. CNA 2 stated she document not applicable on the ADL Task which indicate no bowel movement. CNA 2 stated residents (in general) who had no bowel movement for three days should be communicated to the charge nurse.</p> <p>During a concurrent interview and record review on 11/15/2024, at 1:23 p.m. with Licensed Vocational Nurse (LVN 2), reviewed Resident 45's ADL task. LVN 2 confirmed Resident 45 had no bowel movement for five days and no medications were administered. LVN 2 stated the Resident 45 was on Seroquel and constipation was one of the side effects. LVN 2 stated the charge nurse would ask the residents (in general) if they had bowel movement and check the ADL task for any bowel movement. LVN 2 stated constipation could get worse if the appropriate medications for constipation was not administered and bowel movement was not properly monitored.</p> <p>During an interview on 11/15/2024, at 2:55 p.m. with the Director of Nursing (DON), the DON stated Resident 45's constipation and not having a bowel movement for five days could lead to gastrointestinal complications like fecal impaction and bowel obstruction.</p> <p>During a review of the facility's LVN job description, revised 5/2022, the job description indicated, Monitor residents for and immediately report developments of acute changes of condition including constipation.</p>		

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NAME OF PROVIDER OR SUPPLIER The Earlwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> Administer medications within one hour of their prescribed time as per facility's policy and procedure (P&P) titled, Administering Medications, dated 04/2019, affecting two of five residents observed during medication administration (Resident 1 and 228). Accurately account for the administration of a combination medication, hydrocodone (a controlled substance [a medication with a high potential for abuse used to treat pain] and acetaminophen (APAP - a medication used to treat fever and pain) on Controlled Drug Record (CDR- a log signed by the nurse with the date and time each time a controlled substance is given to a resident) affecting one resident (Resident 332) in one out of two inspected medication carts (Medication Cart 3). <p>These failures have the potential to result in hypertension (HTN - high blood pressure), stroke (loss of blood flow to a part of the brain), venous thromboembolism (blood clots in veins) and hospitalization for Residents 1 and 228, and unintended use of Resident 332's hydrocodone-acetaminophen, placing the facility and residents at risk for medication errors, drug misuse and drug diversion.</p> <p>Findings:</p> <p>1a. During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 11/13/2024, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, acute embolism (a blockage in blood vessel) and thrombosis (blood clotting) of unspecified deep veins of left lower extremity, personal history of transient ischemic attack (a brief episode where blood flow to the brain is temporarily blocked), and cerebral infarction (a condition where blood flow to the brain is blocked) without residual effects, hypertensive (high blood pressure) heart disease without heart failure, anemia (a condition where the body does not have enough healthy red blood cells) and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/27/2024, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance for eating and required partial assistance to supervision for some activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as showering, toileting, dressing and oral hygiene.</p> <p>During an observation of medication administration on 11/13/2024 at 10:30 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered following medications to Resident 1 by 10:46 a.m.</p> <ol style="list-style-type: none"> one tablet of amlodipine (a medication used to treat high blood pressure) 10 milligrams (mg - a unit of measure for mass) <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. one tablet of Eliquis (Generic name - apixaban, a medication used to prevent cerebrovascular accident [CVA] - stroke, loss of blood flow to a part of the brain) 2.5 miligram (mg unit of measurement).</p> <p>3. one tablet of ferrous sulfate (a medication used to treat lack of iron) 325 mg</p> <p>4. one tablet of folic acid (a vitamin B supplement used to treat lack of folic acid) 1000 microgram (mcg - a unit of measure for mass)</p> <p>5. one tablet of hydralazine (a medication used to treat high blood pressure) 50 mg</p> <p>6. 17 grams (gm - a unit of measure for mass) polyethylene glycol (a medication used to relieve constipation) dissolved in water</p> <p>7. one tablet of multivitamin with minerals</p> <p>8. one tablet of risperidone (a medication used to treat mental disorders) 0.5 mg</p> <p>9. one tablet of senna S (a combination of sennosides 8.6 mg and docusate sodium 50 mg - used to treat constipation)</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 1's order entry details and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time for Resident 1's medications were 9 a.m., which indicated the medications were administered one hour and 46 minutes after the scheduled administration time.</p> <p>1b. During a review of Resident 228's Admission Record, dated 11/13/2024, the admission record indicated Resident 228 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to, end stage renal disease (ESRD - irreversible kidney failure), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and recurrent major depressive disorder.</p> <p>During a review of Resident 228's MDS, dated [DATE], the MDS indicated Resident 228's cognition was intact. The MDS indicated Resident 228 required partial or moderate assistance for eating and oral hygiene. The MDS indicated Resident 228 was fully dependent or required maximal assistance for toileting, showering and dressing.</p> <p>During an observation of medication administration on 11/13/2024 at 10:57 a.m. with LVN 1, LVN 1 prepared and administered following medications to Resident 228:</p> <p>1. one tablet of escitalopram (a medication used to treat depression and mood disorders) 10 mg</p> <p>2. one tablet of multivitamin with minerals</p> <p>3. one tablet of zinc 50 mg</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. one tablet of amlodipine 5 mg</p> <p>5. one tablet of hydralazine 25 mg</p> <p>6. one tablet of risperidone 0.25 mg</p> <p>7. one milliliter (mL - a unit of measure for volume) or 5000 units of Heparin (a medication used to prevent blood clots)</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 228's order entry details and MAR dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time for Escitalopram 10 mg was 7 a.m. and for the remaining medications, the scheduled administration time was 8 a.m., which indicated Escitalopram was administered four hours after scheduled administration time and other medications were administered three hours after their scheduled administration time.</p> <p>During an interview on 11/13/2024 at 3:00 p.m. with LVN 1, LVN 1 stated medications for Residents 1, 228 and other residents should have been administered at the prescribed time or within one hour before or one hour after prescribed administration time. LVN 1 stated she usually worked on the other side of the facility and was not completely familiar with residents on this side. LVN 1 stated that there was an increased risk of hypertension, deep venous thrombosis, blood clotting, mood change or agitation and hospitalization for residents when the medications were not administered on time.</p> <p>During an interview on 11/13/2024 at 1:29 p.m. and on 11/14/2024 at 4:41 p.m. with the Director of Nursing (DON), DON stated the medications should have been administered at prescribed time or within one hour before or one hour after prescribed administration time. DON stated if medications for Resident 1, 228 and other residents were administered outside of the one-hour timeframe, then they were considered as late administration. DON stated the facility staff would need to be retrained for order entry because the medication orders that were entered with 7 a.m. and 8 a.m. times were supposed to be entered with 9 a.m. scheduled administration. DON stated late administration of antihypertensive medications, Eliquis and psychotropic medications placed the residents at an increased risk for uncontrolled blood pressure, stroke, thrombosis, clotting, heart complications, mood and behavioral problems, and hospitalization .</p> <p>2. During a review of Resident 332's Admission Record, dated 11/14/2024, the admission record indicated Resident 332 was admitted to the facility on [DATE] with diagnosis including but not limited to, low back pain.</p> <p>During a review of Resident 332's Order Summary Report (a list of all currently active medical orders), dated 11/14/2024, the document indicated the following physician order:</p> <p>Norco Oral Tablet 10-325 mg (generic name - hydrocodone-acetaminophen) give 1 tablet by mouth every 4 hours as needed for severe pain 8-10 do not exceed more than 3 gm of APAP within 24 hours from all sources, hold for respiration rate (RR) less than (<) 12 or sedation, order date 11/7/2024, start date 11/7/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation of Medication cart 3, interview and record review on 11/14/2024 at 1:03 p.m. with LVN 4, Resident 332's medication card / bubble pack for hydrocodone-APAP 10-325 mg, facility's CDR and the medication administration details were reviewed. Resident 332's medication card / bubble pack for hydrocodone-APAP 10-325 mg contained a quantity of 26 tablets remaining. The facility's CDR indicated a quantity of 27 tablets remaining with the last dose administered on 11/13/2024 at 10:22 a.m. The administration details indicated hydrocodone-APAP 10-325 mg for Resident 332 was administered on 11/14/2024 at 8:20 a.m. LVN 4 stated hydrocodone-APAP 10-325 mg was administered to Resident 332 on 11/14/2024 at 8:20 a.m. and the book (CDR) should have been documented and signed immediately after medication was administered. LVN 4 stated there was a possibility of medication error causing underdosing or overdosing of medication, drug misuse, and diversion if the medication was not documented accurately in the book after it was administered to resident.</p> <p>During an interview on 11/14/2024 at 4:31 p.m. with DON, DON stated it was important that LVN 4 documented the controlled drug record immediately after administering the hydrocodone-APAP to ensure that the medication was given. DON stated if the CDR was not documented, it would become questionable if the medication was administered. DON stated by not documenting controlled substances, it increased the risk for medication error, drug misuse, and diversion.</p> <p>During a review of the facility's P&P titled, Administering Medications, dated 04/2019, the P&P indicated, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>During a review of the facility's P&P titled, Medication Errors, dated 6/28/2022, the P&P indicated, medication error means the administration of medication at the wrong time.</p> <p>During a review of the facility's P&P, titled, Controlled Substances, dated 11/2022, the P&P indicated, The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a) Records of personnel access and usage; b) Medication administration records; c) Declining inventory records; and d) Destruction, waste and return to pharmacy records. The P&P indicated, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion loss/diversion and detection/follow-u</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889</p> <p>Based on interview and record review the facility failed to ensure two of three sampled resident (Resident 25 and 29) was free from unnecessary medication. The facility failed to:</p> <p>a. Ensure Resident 25 continued use of antibiotic was reviewed when Resident 25 did not meet LOEB's criteria (set of guidelines used by healthcare providers in for long term care facilities to determine when a resident likely has a significant infection and needs antibiotics based on symptoms) indicating antibiotic use.</p> <p>This deficient practice of failing to ensure a continued need for antibiotics (medications that fight bacterial infections) increased the risk for Resident 25 to experienced antibiotic resistance (when bacteria change to resist antibiotics used to effectively treat them) from unnecessary antibiotic use.</p> <p>b. Ensure Resident 29 Tramadol (pain medication) was given according to physician orders.</p> <p>c. Ensure Resident 29 Morphine sulfate (pain medication) was given according to physician orders.</p> <p>These failures had the potential to put Resident 29's safety at risk when not following the medication parameter (ensures medications are given correctly) orders for administering pain medications.</p> <p>Findings:</p> <p>a. During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility 4/19/2022 with diagnoses including diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing) and cerebral infarction (a part of the brain has been damaged because it wasn't getting enough blood supply).</p> <p>During a review of Resident 25's Minimum Data Set ([MDS]- a resident assessment tool), the MDS indicated Resident 25 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent with bathing, toileting, and transferring.</p> <p>During a review of Resident 25's Antibiotic Surveillance Data Collection dated 10/17/2024, the Antibiotic Surveillance Data Collection indicated Resident 25 did not have the LOEB's criteria (set of guidelines used by healthcare providers in for long term care facilities to determine when a resident likely has a significant infection and needs antibiotics based on symptoms) indicating antibiotic use.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 11/15/2024 at 9:32 a.m., with the Infection Prevention Nurse (IPN), the IPN stated Resident 25 was prescribed Ciprofloxacin (medication to treat a bacterial infection) but did not meet the LOEBS criteria. IPN stated Resident 25 was prescribed Keflex (medication to treat infection) from 10/17/24 to 10/24/2024 and then Ciprofloxacin from 10/29/2024 to 11/5/2024. IPN stated she spoke with Resident 25's primary physician that ordered the antibiotic and he still wanted the resident to receive the Ciprofloxacin despite not meeting the criteria. IPN stated she did not reach out to the facility's Medical Director (MD), and should have done so, to inform him Resident 25 did not meet the criteria for antibiotic use.</p> <p>During an interview on 11/15/2024 at 12:17 a.m., with the Director of Nursing (DON), the DON stated Resident 25 should not have been prescribed Ciprofloxacin because he did not meet the LOEBS criteria. The DON stated the MD should have been involved. The DON stated unnecessary medications like use of antibiotics can cause antibiotic resistance.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Utilization and Prescribing-Clinical Protocol, revised April 2018, the P&P indicated, When a medication is prescribed for any reason, the physician and staff will identify the indications, considering the residents age, medical conditions, risks, health status, and existing regimen. A diagnosis by itself may not be sufficient justification for prescribing a medication. The existence of a condition or risk does not necessarily require a treatment and the treatment may be something besides, or in addition to, medication. The physician will participate in the facility's antibiotic stewardship protocols, including documentation of the clinical criteria for infection and laboratory reports of susceptibility, if necessary, when an antibiotic is ordered.</p> <p>Cross Reference F881</p> <p>b. During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was admitted to the facility on [DATE] with the diagnoses including major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), diabetes type 2 (DM a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (feels of worry or fear).</p> <p>During a review of Resident 29's MDS, dated [DATE] indicated Resident 29 has severe cognitive impairment.</p> <p>During a review of resident 29's History and Physical, dated 6/19/2024 indicated Resident 29 does not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 29's Physician Order Summary Report dated 11/15/2024 indicated Resident 29 had orders to monitor pain level every shift using the pain rating scale (a tool that helps people measure their pain so that doctors can plan treatment and monitor its effectiveness) one to four for mild pain, five to seven for moderate pain and eight to 10 for severe pain. Resident 29 had orders for acetaminophen 650 milligram (mg unit of measurement) insert one suppository rectally every six hours as needed for one to four for mild pain, do not exceed more than 3 grams of acetaminophen within 24 hours. Resident 29 had orders for Tramadol oral tablet 50 mg one tablet by mouth at bedtime for pain and tramadol oral tablet 50 mg one tablet by mouth every 6 hours as needed for five to seven for moderate pain. Resident 29 had orders for Morphine Sulfate oral solution 100mg/5 milliliter (ml-unit of measurement) give 0.25 ml sublingually (under the tongue every two hours as needed for moderate to eight to 10 for severe pain.</p> <p>During a review of Resident 29's Medication Administration Record (MAR) dated 11/15/24, the MAR indicated that on 11/2/2024 Resident 29 was given Tramadol 50 mg by mouth for a pain level of three (mild pain), and on 11/5/24 Resident 29 was given Tramadol 50mg by mouth for a pain level of four (mild pain). On 11/1/2024, 11/6/2024, 11/7/2024 and 11/13/2024. Resident 29 received Morphine 0.25 ml sublingual on for a pain level of zero. On 11/12/24, and 11/13/24 Resident 29 was given Morphine 0.25 ml for a pain level of three (mild pain). On 11/8/24 Resident 29 received Morphine 0.25ml for a pain level of five (moderate pain).</p> <p>During a concurrent interview and record review on 11/15/2024. at 10:08 a.m., with Assistant Director of Nurses (ADON), reviewed Resident 29's MAR for 11/2024. The ADON stated Resident 29 should not have been given tramadol or morphine on 11/5/24, 11/1/2024, 11/6/2024, 11/7/2024, 11/8/2024, 11/12/2024 and 11/13/2024. The ADON stated licensed nurses did not follow Resident 29's physician orders when Resident 29 received pain medication for the documented pain levels. The ADON stated resident was at risk for overdose when giving pain medication for the wrong indications.</p> <p>During a concurrent interview and record review on 11/15/2024 at 10:18 a.m., with the Director of Nurses (DON), reviewed Resident 19's MAR for 11/2024. The DON stated that licensed nurses should not have given the Tramadol or Morphine for those documented pain levels on those specific dates. The DON stated that licensed nurses did not follow Resident 29's physician orders when the pain medications were given not according to Resident 29 pain level. The DON stated that Resident 29 was at risk for possible adverse side effects of the medications when not following physician orders.</p> <p>During a review of the facilities policy and procedure (P&P) titled Administering Medications dated 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130</p> <p>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of five sampled residents (Resident 1 and 228) by failing to provide medications within one (1) hour of the prescribed time of administration as per facility's policy and procedure (P&P) titled, Administering Medications, dated 04/2019.</p> <p>This deficient practice of medication administration error rate of 25.93% exceeded the five (5) percent threshold.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 11/13/2024, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, acute embolism (a blockage in blood vessel) and thrombosis (blood clotting) of unspecified deep veins of left lower extremity, personal history of transient ischemic attack (a brief episode where blood flow to the brain is temporarily blocked), and cerebral infarction (a condition where blood flow to the brain is blocked) without residual effects, hypertensive (high blood pressure) and heart disease without heart failure.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/27/2024, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance for eating and required partial assistance to supervision for some activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as showering, toileting, dressing and oral hygiene.</p> <p>During a review of Resident 1's Order Summary Report (a document containing a summary of all active physician orders), dated 11/13/2024, the order summary report included, but not limited to the following medications:</p> <p>a. Amlodipine besylate (a medication used to treat high blood pressure) tablet 10 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth one time a day for HTN, hold for systolic blood pressure (SBP - the pressure in arteries when heart is pumping blood into arteries) <110, order date 12/26/2022.</p> <p>b. Eliquis (Generic name - apixaban, a medication used to prevent cerebrovascular accident [CVA] - stroke, loss of blood flow to a part of the brain) oral tablet 2.5 mg, give 1 tablet by mouth two times a day for deep vein thrombosis (DVT - a medical condition when a blood clot forms in a vein deep inside the body) prophylaxis (prevention), order date 5/17/2024.</p> <p>c. Hydralazine hydrochloride (HCl) (a medication used to treat high blood pressure) tablet 50 mg, give 1 tablet by mouth two times a day for HTN, hold for SBP <110, order date 12/26/2022.</p> <p>(continued on next page)</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of medication administration on 11/13/2024 from 10:30 a.m. to 10:46 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered Resident 1's medications that included (but not limited to) 1 tablet of Amlodipine 10 mg, 1 tablet of Eliquis 2.5 mg and 1 tablet of Hydralazine 50 mg.</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 1's order entry details and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time was 9 a.m. for Amlodipine 10 mg, Eliquis 2.5 mg and Hydralazine 50 mg. However, LVN 1 was observed administering Resident 1's Amlodipine, Eliquis and Hydralazine at 10:46 a.m. on 11/13/2024, which was one hour and 46 minutes after the scheduled administration time of 9 a.m.</p> <p>During an interview on 11/13/2024 at 3:00 p.m. with LVN 1, LVN 1 stated the scheduled administration time for Resident 1's medications was 9 a.m. and should have been administered at the prescribed time or before 10 a.m. LVN 1 stated that there was an increased risk of hypertension, deep venous thrombosis, blood clotting, and hospitalization for Resident 1 when the medications were not administered on time.</p> <p>2. During a review of Resident 228's Admission Record, dated 11/13/2024, the admission record indicated Resident 228 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to, end stage renal disease (ESRD - irreversible kidney failure), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and recurrent major depressive disorder.</p> <p>During a review of Resident 228's MDS, dated [DATE], the MDS indicated Resident 228's cognition was intact. The MDS indicated Resident 228 required partial or moderate assistance for eating and oral hygiene. The MDS indicated Resident 228 was fully dependent or required maximal assistance for toileting, showering and dressing.</p> <p>During a review of Resident 228's Order Summary Report, dated 11/13/2024, the order summary included, but not limited to the following medications:</p> <p>a. Amlodipine oral tablet 5 mg, give 1 tablet by mouth in the morning for hypertension, order date 11/11/2024.</p> <p>b. Escitalopram (a medication used to treat depression and mood disorders) oral tablet 10 mg, give 1 tablet by mouth in the morning for depression and anxiety, order date 11/11/2024.</p> <p>c. Heparin (a medication used to prevent blood clots) sodium injection 5000 units / milliliter (mL - a unit of measure for volume), inject 1 mL subcutaneously (under the skin) every 12 hours for venous thromboembolism (VTE -a condition with blood clot in veins) prophylaxis, order date 11/11/2024.</p> <p>d. Hydralazine HCl oral tablet 25 mg, give 1 tablet by mouth two times a day for hypertension, order date 11/11/2024.</p> <p>(continued on next page)</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of medication administration on 11/13/2024 at 10:57 a.m. with LVN 1, LVN 1 prepared and administered Resident 228's medications that included (but not limited to) 1 tablet of Escitalopram 10 mg, 1 tablet of Amlodipine 5 mg, 1 tablet of Hydralazine 25 mg and 1 mL or 5000 units of Heparin.</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 228's order entry details and MAR dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time was 7 a.m. for Escitalopram 10 mg, 8 a.m. for Amlodipine 5 mg, Heparin 5000 units and Hydralazine 25 mg. However, LVN 1 was observed administering Resident 228's Escitalopram 10 mg, Amlodipine 5 mg, Heparin 5000 units (1 mL) and Hydralazine 25 mg at 10:57 a.m. on 11/13/2024, which was almost four hours after the scheduled administration time of 7 a.m. for Escitalopram, and three hours after the scheduled administration time of 8 a.m. for Amlodipine, Heparin and Hydralazine.</p> <p>During an interview on 11/13/2024 at 3:00 p.m. with LVN 1, LVN 1 stated the Resident 228's medications should have been administered at the prescribed time or within one hour before or one hour after scheduled administration time. LVN 1 stated that there was an increased risk of hypertension, deep venous thrombosis, blood clotting, mood change or agitation and hospitalization for Resident 228 when the medications were not administered on time.</p> <p>During an interview on 11/13/2024 at 1:29 p.m. and on 11/14/2024 at 4:41 p.m. with the Director of Nursing (DON), DON stated the medications should have been administered at prescribed time or within one hour before or one hour after prescribed administration time. DON stated if medications for Residents 1 and 228 were administered outside of the one-hour timeframe, then they were considered as late administration. DON stated the facility staff would need to be retrained for order entry because the medication orders that were entered with 7 a.m. and 8 a.m. times were supposed to be entered with 9 a.m. scheduled administration. DON stated late administration of antihypertensive medications, Eliquis and psychotropic medications placed the residents at an increased risk for uncontrolled blood pressure, stroke, thrombosis, clotting, heart complications, mood and behavioral problems, and hospitalization .</p> <p>During a review of the facility's P&P titled, Administering Medications, dated 04/2019, the P&P indicated, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>During a review of the facility's P&P titled, Medication Errors, dated 6/28/2022, the P&P indicated, a. The facility will work to keep medication error rates five percent or lower. b. Medication error means the administration of medication at the wrong time.</p>		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for two (Resident 1 and 228) of five sampled residents, by failing to administer:</p> <ol style="list-style-type: none"> 1. Resident 1's Amlodipine (a medication used to treat high blood pressure), Eliquis (Generic name - apixaban, a medication used to prevent cerebrovascular accident [CVA] - stroke, loss of blood flow to a part of the brain) and Hydralazine (a medication used to treat high blood pressure) within one (1) hour of the prescribed time of administration as per facility's policy and procedure (P&P) titled, Administering Medications, dated 04/2019. 2. Resident 228's Amlodipine, Escitalopram (a medication used to treat depression and mood disorders), Heparin (a medication used to prevent blood clots) and Hydralazine within one (1) hour of the prescribed time of administration as per facility's P&P titled, Administering Medications, dated 04/2019. <p>These failures had the potential to result in hypertension (HTN - high blood pressure), stroke (loss of blood flow to a part of the brain), venous thromboembolism (blood clots in veins), behavioral disturbances and hospitalization for Residents 1 and 228.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 11/13/2024, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, acute embolism (a blockage in blood vessel) and thrombosis (blood clotting) of unspecified deep veins of left lower extremity, personal history of transient ischemic attack (a brief episode where blood flow to the brain is temporarily blocked), and cerebral infarction (a condition where blood flow to the brain is blocked) without residual effects, hypertensive (high blood pressure) and heart disease without heart failure. <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/27/2024, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance for eating and required partial assistance to supervision for some activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as showering, toileting, dressing and oral hygiene.</p> <p>During a review of Resident 1's Order Summary Report (a document containing a summary of all active physician orders), dated 11/13/2024, the order summary report included, but not limited to the following medications:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Amlodipine besylate (a medication used to treat high blood pressure) tablet 10 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth one time a day for HTN, hold for systolic blood pressure (SBP - the pressure in arteries when heart is pumping blood into arteries) <110, order date 12/26/2022.</p> <p>b. Eliquis (Generic name - apixaban, a medication used to prevent cerebrovascular accident [CVA] - stroke, loss of blood flow to a part of the brain) oral tablet 2.5 mg, give 1 tablet by mouth two times a day for deep vein thrombosis (DVT - a medical condition when a blood clot forms in a vein deep inside the body) prophylaxis (prevention), order date 5/17/2024.</p> <p>c. Hydralazine hydrochloride (HCl) (a medication used to treat high blood pressure) tablet 50 mg, give 1 tablet by mouth two times a day for HTN, hold for SBP <110, order date 12/26/2022.</p> <p>During an observation of medication administration on 11/13/2024 from 10:30 a.m. to 10:46 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered Resident 1's medications that included (but not limited to) 1 tablet of Amlodipine 10 mg, 1 tablet of Eliquis 2.5 mg and 1 tablet of Hydralazine 50 mg.</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 1's order entry details and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time was 9 a.m. for Amlodipine 10 mg, Eliquis 2.5 mg and Hydralazine 50 mg. However, LVN 1 was observed administering Resident 1's Amlodipine, Eliquis and Hydralazine at 10:46 a.m. on 11/13/2024, which was one hour and 46 minutes after the scheduled administration time of 9 a.m.</p> <p>During an interview on 11/13/2024 at 3:00 p.m. with LVN 1, LVN 1 stated the scheduled administration time for Resident 1's medications was 9 a.m. and should have been administered at the prescribed time or before 10 a.m. LVN 1 stated that there was an increased risk of hypertension, deep venous thrombosis, blood clotting, and hospitalization for Resident 1 when the medications were not administered on time.</p> <p>2. During a review of Resident 228's Admission Record, dated 11/13/2024, the admission record indicated Resident 228 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to, end stage renal disease (ESRD - irreversible kidney failure), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and recurrent major depressive disorder.</p> <p>During a review of Resident 228's MDS, dated [DATE], the MDS indicated Resident 228's cognition was intact. The MDS indicated Resident 228 required partial or moderate assistance for eating and oral hygiene. The MDS indicated Resident 228 was fully dependent or required maximal assistance for toileting, showering and dressing.</p> <p>During a review of Resident 228's Order Summary Report, dated 11/13/2024, the order summary included, but not limited to the following medications:</p> <p>a. Amlodipine oral tablet 5 mg, give 1 tablet by mouth in the morning for hypertension, order date 11/11/2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Escitalopram (a medication used to treat depression and mood disorders) oral tablet 10 mg, give 1 tablet by mouth in the morning for depression and anxiety, order date 11/11/2024.</p> <p>c. Heparin (a medication used to prevent blood clots) sodium injection 5000 units / milliliter (mL - a unit of measure for volume), inject 1 mL subcutaneously (under the skin) every 12 hours for venous thromboembolism (VTE -a condition with blood clot in veins) prophylaxis, order date 11/11/2024.</p> <p>d. Hydralazine HCl oral tablet 25 mg, give 1 tablet by mouth two times a day for hypertension, order date 11/11/2024</p> <p>During an observation of medication administration on 11/13/2024 at 10:57 a.m. with LVN 1, LVN 1 prepared and administered Resident 228's medications that included (but not limited to) 1 tablet of Escitalopram 10 mg, 1 tablet of Amlodipine 5 mg, 1 tablet of Hydralazine 25 mg and 1 mL or 5000 units of Heparin.</p> <p>During a medication reconciliation review on 11/13/2024 at 12:08 p.m., Resident 228's order entry details and MAR dated 11/13/2024 were reviewed. The order details and MAR indicated the scheduled administration time was 7 a.m. for Escitalopram 10 mg, 8 a.m. for Amlodipine 5 mg, Heparin 5000 units and Hydralazine 25 mg. However, LVN 1 was observed administering Resident 228's Escitalopram 10 mg, Amlodipine 5 mg, Heparin 5000 units (1 mL) and Hydralazine 25 mg at 10:57 a.m. on 11/13/2024, which was almost four hours after the scheduled administration time of 7 a.m. for Escitalopram, and three hours after the scheduled administration time of 8 a.m. for Amlodipine, Heparin and Hydralazine.</p> <p>During an interview on 11/13/2024 at 3:00 p.m. with LVN 1, LVN 1 stated the Resident 228's medications should have been administered at the prescribed time or within one hour before or one hour after scheduled administration time. LVN 1 stated that there was an increased risk of hypertension, deep venous thrombosis, blood clotting, mood change or agitation and hospitalization for Resident 228 when the medications were not administered on time.</p> <p>During an interview on 11/13/2024 at 1:29 p.m. and on 11/14/2024 at 4:41 p.m. with the Director of Nursing (DON), DON stated the medications should have been administered at prescribed time or within one hour before or one hour after prescribed administration time. DON stated if medications for Resident 1, 228 and other residents were administered outside of the one-hour timeframe, then they were considered as late administration. DON stated the facility staff would need to be retrained for order entry because the medication orders that were entered with 7 a.m. and 8 a.m. times were supposed to be entered with 9 a.m. scheduled administration. DON stated late administration of antihypertensive medications, Eliquis and psychotropic medications placed the residents at an increased risk for uncontrolled blood pressure, stroke, thrombosis, clotting, heart complications, mood and behavioral problems, and hospitalization .</p> <p>During a review of the facility's P&P titled, Administering Medications, dated 04/2019, the P&P indicated, Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>During a review of the facility's P&P titled, Medication Errors, dated 6/28/2022, the P&P indicated, medication error means the administration of medication at the wrong time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49130</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Insulin Lispro prefilled pens [a type of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) delivered via injection device] were stored and/or labeled in accordance with manufacturer's specifications and facility's policy and procedure (P&P) titled Medication Labeling and Storage, dated 02/2023 affecting two residents (Resident 4 and 62) in one of two inspected medication carts (Medication Cart 3). 2. Ensure a single dose vial of Retacrit (generic name - epoetin alfa-epbx, a medication used to treat anemia (a condition where the body does not have enough healthy red blood cells) was removed and/or discarded after being opened in accordance with manufacturer's specifications affecting one resident (Resident 50) in one of two inspected medication carts (Medication Cart 3). <p>These failures have the potential to result in Residents 4, 50 and 62 receiving medications that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications such as hyperglycemia (high blood glucose [simple sugar- the body's primary source of energy from food]) and anemia.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation and inspection on 11/14/2024 at 12:06 p.m. of Medication Cart 3 with Licensed Vocational Nurse (LVN) 4, the following medications were found stored under a different medication label and/or labeled with two different opened dates, which was not in accordance with manufacturer's requirements: <ol style="list-style-type: none"> 1a. Insulin Lispro 100 units (a unit of measurement for insulin) / milliliters (mL - a unit of measure for volume) prefilled pen for Resident 62 labeled with two different opened dates. <p>The label on outer bag containing insulin lispro prefilled pen indicated opened date of 11/22/2024. The label on insulin lispro prefilled pen inside the bag indicated opened date of 11/12/2024.</p> <ol style="list-style-type: none"> 1b. Two Insulin Lispro 100 units/mL prefilled pens for Resident 4 inside one bag that was labeled with a different medication name for Resident 4. <p>The label on outer bag indicated Basaglar (Generic name - Insulin Glargine) KwikPen 100 units/mL for Resident 4 with an opened date of 10/23/2024. The bag contained two insulin lispro prefilled pens with two different opened dates:</p> <p>One insulin lispro prefilled pen inside the bag for Resident 4 indicated an opened date of 10/31/2024.</p> <p>(continued on next page)</p> 		

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NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 20820 Earl Street Torrance, CA 90503	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One insulin lispro prefilled pen inside the bag for Resident 4 indicated an opened date of 10/30/2024.</p> <p>According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature, below 86-degree Fahrenheit [(F) is a unit of temperature] (30-degree Celsius [(C) is a unit of temperature], insulin lispro and Basaglar prefilled pen must be used within 28 days or be discarded.</p> <p>During a subsequent interview on 11/14/2024 at 12:06 p.m. with LVN 4, LVN 4 stated the insulin lispro for Resident 62 was labeled with two different opened dates for insulin lispro prefilled pen. LVN 4 stated this could lead to confusion and misunderstanding, so should have been labeled better. LVN 4 stated she needed to take a break.</p> <p>During a subsequent interview on 11/14/2024 at 12:06 p.m. with Minimum Data Set Coordinator (MDSC) and LVN, MDSC stated, there was no risk for medication error for Resident 62 and Resident 4 because she would look at the electronic medical administration record (eMAR) not the outer bag label before administering medication. MDSC stated the LVNs were supposed to follow the order on eMAR and so did not see how this could lead to a medication error.</p> <p>During an interview on 11/14/2024 at 4:13 p.m., with Director of Nursing (DON), DON stated, the LVN was getting defensive, and it was a bad practice when the label on outer bag was labeled with a different medication name than the labels on the pens stored inside the bag. DON stated this practice could lead to a medication error causing abnormal blood glucose levels and hospitalization because different LVNs could interpret the medication labels and doses differently.</p> <p>2. During an observation and inspection on 11/14/2024 at 12:30 p.m. of Medication Cart 3 with LVN 4, the medication cart contained an opened single dose vial of Retacrit 4,000 units/mL for Resident 50 with no open date and/or expiration date documented on the vial, which was not in accordance with manufacturer's requirements.</p> <p>According to the manufacturer's product labeling, Retacrit 4,000 units/mL single dose vial should be stored refrigerated at 2 C to 8 C (36 F to 46 F).</p> <p>During an interview on 11/15/2024 at 10:33 a.m. with LVN 4, LVN 4 stated the last administration of Retacrit to Resident 50 was on 11/11/2024. LVN 4 stated the single dose vial should have been discarded after it was opened and used otherwise Retacrit should be stored in the refrigerator if not in use. LVN 4 stated if the remaining medication from the opened vial was used, or if medication was not administered, there was a risk that Resident 50's hemoglobin (Hgb - a protein in red blood cells that carries oxygen throughout the body) could drop, leading to blood transfusion and hospitalization .</p> <p>During an interview on 11/15/2024 at 12:54 p.m. with DON, DON stated Retacrit single dose vial was supposed to be stored in the refrigerator until it was opened. DON stated single dose vial should be discarded after it was opened. DON stated there was a risk of anemia and would not improve Resident 50's hemoglobin if the improperly stored Retacrit was administered to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 11/15/2024 at 12:19 p.m. with pharmacist (RPH) 1 at pharmacy (PH) 1, RPH 1 stated pharmacy would not and did not store multiple different medications requiring refrigeration in one bag with a different medication's pharmacy label. RPH 1 stated if the product was an insulin vial and/or pen, there would be a separate small label on vial and/or pen indicating resident name and there would be a pharmacy label on the outer bag matching details of the product inside the bag.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 02/2023, the P&P indicated, Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received .only the issuing pharmacy is authorized to transfer medications between containers. The P&P indicated, labeling of medications and biologicals dispensed by the pharmacy is consistent with and currently accepted pharmaceutical practices. The P&P indicated, The medication label includes .expiration date, when applicable .precautions. The P&P indicated, multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days .shorter or longer date for the open vial.</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889</p> <p>Based on observation interview and record review the facility failed to:</p> <p>a.Ensure an open container of apple sauce had an open date and a use by date on the container.</p> <p>b.Ensure an open container of beef base had an open date and a use by date on the container.</p> <p>c.Ensure frozen chicken tenders that were stored in a Ziploc bag had an open date and a use by date on the bag.</p> <p>d.Ensure that pork was defrosted safely, when pork was left in a bowl of standing water while defrosting in the sink.</p> <p>These failures had the potential to expose residents to a food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites).</p> <p>Findings:</p> <p>a. During an interview on [DATE] at 2:15 p.m., with the Dietary Aide (DA) the DA stated all opened food container must have an open date and use by date on the container, so staff would know when the food was no longer good to use. DA stated there was a potential for a food born illness if food was used after the expiration date.</p> <p>During a concurrent observation and interview on [DATE]. at 8:05 a.m., with Dietary Manager (DM), DM stated that the apple sauce, beef base and frozen chicken tenders did not have an open date or use by date on the containers. DM stated that all food that was opened must have an open date and use by date on the container. DM stated, staff need to know the correct open date, without that date the staff won't be able to know how old the food was. DM stated that there was a possibility for of a food born illnesses when expired foods are served to the vulnerable residents.</p> <p>During an interview on [DATE] at 9:05 a.m., with the Director of Nurses (DON), the DON stated that open dates and use by dates must be on all food that was opened, to ensure food was fresh and not expired. The DON stated there was a possibility for bacteria to grow and that the residents are at risk for a food born illnesses when served with expired foods.</p> <p>b. During an interview on [DATE] at 8:37 a.m., with the Cook, the [NAME] stated that when defrosting pork in the sink the cold water must be running on the meat until just before cooking it. The [NAME] stated that meat should never be left in standing water because there was a possibility for bacteria to grow on the food and the residents could get sick.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on [DATE], at 8:05 a.m., with Dietary Manager (DM), the DM stated she put the pork in the sink in the morning ([DATE]) to defrost it. DM stated that she had turned on the cold water and that someone must have turned the water off. The DM stated that when defrosting pork in the sink, cold water must always run on the pork. DM stated if there was no cold water running on the pork the meat could heat up to the food temperature danger zone where bacteria starts to grow. DM stated that residents are at risk for food born illnesses when not defrosting meat properly.</p> <p>During an interview [DATE] at 9:05 a.m., with the Director of Nurses (DON), the DON stated, that the right way to thaw out pork was to have cold water running on it while it was defrosting. The DON stated that bacteria could grow on the pork if not defrosted properly and the residents are at risk for a food born illnesses.</p> <p>During a review of the facilities policy and procedure (P&P) titled Receiving dated ,d+[DATE] indicated, safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items.</p> <p>All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation.</p> <p>All food items will be stored in a manner that ensures appropriate and timely utilization based on the principles of first in- first out (FIFO) inventory management.</p> <p>During a review of the facilities P&P titled Food Preparation dated ,d+[DATE] indicated, All foods are prepared in accordance with the Food Drug Administration Food Code.</p> <p>The Cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods:</p> <p>Thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross-contamination.</p> <p>Thawing the item in a microwave oven, then transferring immediately to conventional cooking equipment.</p> <p>Completely submerging the item under cold water (at a temperature of 70 For below) that is running fast enough to agitate and float off loose ice particles.</p> <p>Cooking directly from the frozen state, when directed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) Records for one of four sample residents (Resident 17) with limitation in range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) indicated Resident 17's refusal to wear the right elbow splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) on 11/12/2024.</p> <p>This failure resulted in the inaccurate provision of care recorded in Resident 17's clinical records.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), aphasia (loss of ability to understand or express speech as a result of brain damage), hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side, and acquired absence of the left leg above the knee.</p> <p>During a review of Resident 17's Minimum Data Set ([MDS] a resident assessment tool), dated 10/4/2024, the MDS indicated Resident 17 did not have any speech, rarely/never understood others, rarely/never expressed ideas, and wants, and was severely impaired for daily decision making. The MDS indicated Resident 17 had ROM limitations in one arm and one leg. The MDS also indicated Resident 17 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) with toileting, dressing, lying to sitting on the side of the bed, and chair/bed-to-chair transfer.</p> <p>During a review of Resident 17's Physician Orders, dated 5/16/2022, the Physician Orders indicated for the RNA to perform passive range of motion ([PROM] movement of joint through the ROM from an external force with no effort from the person) on Resident 17's right arm, five times per week as tolerated.</p> <p>During a review of Resident 17's Physician Orders, dated 10/26/2023, indicated for the RNA to apply a right elbow splint and a right-hand splint, five times per week for three hours as tolerated.</p> <p>During an observation on 11/12/2024 at 11:06 a.m. in Resident 17's room, Resident 17 was lying awake in bed and moved the left arm normally. Resident 17's right shoulder was positioned in internal rotation (arm rotated toward the body), the right elbow was bent more than 90 degrees, the right wrist was positioned in extension (bent upward) while wearing a right-hand splint, and the right fingers were bent. Resident 17 was observed not wearing a right elbow splint.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 11/13/2024 at 9:53 a.m. in Resident 17's room, Resident 17's RNA session with Restorative Nursing Aide 1 (RNA 1) and RNA 2 was observed. RNA 1 stood on the right side of Resident 17's bed while RNA 2 stood on the left side of the bed. RNA 1 performed PROM exercises to Resident 17's right shoulder, elbow, wrist, and hand. RNA 1 applied Resident 17's right-hand splint, but Resident 17 refused the application of the right elbow extension splint.</p> <p>During an interview on 11/13/2024 at 10:06 a.m. with RNA 1 and RNA 2, RNA 1 stated Resident 17 refused the right elbow splint but will attempt to place the splint again later in the day. RNA 2 stated Resident 17 also refused to apply the right elbow splint yesterday (11/12/2024).</p> <p>During a review of Resident 17's RNA Record (record of RNA sessions) for 11/2024, the RNA Record indicated Resident 17's right elbow splint was applied on 11/12/2024 and refused on 11/13/2024.</p> <p>During a concurrent interview and record review on 11/14/2024 with RNA 2, Resident 17's RNA Record for 11/2024 was reviewed. RNA 2 stated Resident 17 allowed RNA 2 to perform the PROM exercises on the right arm and application of the right-hand splint but refused the right elbow splint application on 11/12/2024. RNA 2 reviewed Resident 17's RNA record for 11/12/2024 and stated she should have indicated Resident 17 refused the right elbow splint.</p> <p>During a concurrent interview and record review on 11/15/2024 with the Director of Staff Development (DSD), Resident 17's RNA Record for 11/12/2024 was reviewed. The DSD stated the RNAs should circle their initial and write on the back of the RNA Record if a resident (in general) refused to participate in RNA exercises or application of splints. The DSD reviewed Resident 17's RNA Record for 11/12/2024, which included the RNA's initial but not circled. The DSD stated it was important to indicate in the documentation when a resident refuses treatment to notify the family for assistance or the resident's physician for recommendations.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Nursing Documentation, dated 6/27/2022, the P&P indicated nursing documentation will be accurate based on the resident's condition.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145</p> <p>Based on observation, interview, and record review the facility failed to implement infection control practices to prevent the spread and transmission of infection. The facility failed to:</p> <p>a. Ensure hand hygiene was performed at appropriate times during a gastrostomy tube ([GT]- a tube inserted through the wall of the abdomen directly into the stomach) site dressing change for Resident 6.</p> <p>b. Observe Contact Precautions (are set of safety measures used when a resident has a disease that can be spread thru contact with the patient or patient's environment) before entering Resident 22's room who had a methicillin resistant staphylococcus aureus (MRSA-type of bacterial infection that is resistant to many antibiotics) and Candida Auris(C. Auris- type of yeast or fungus that can cause serios infections and are difficult to treat because it is resistant to many antifungal medications).</p> <p>c. Ensure laundry staff performed hand hygiene (any action of hand cleansing) and used Personal Protective Equipment ([PPE] clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) including a gown, polyvinyl chloride (PVC) dipped gloves (gloves that offer more durability and chemical resistance), and eye protection with a face shield or goggles while handling soiled linen.</p> <p>d. Ensure clean linen was fully covered during transport to the clean linen carts located in the facility's hallways.</p> <p>These failures had the potential to result in the spread of diseases and infection to the facility staff, residents, and visitors.</p> <p>Findings:</p> <p>a. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), dementia (a progressive state of decline in mental abilities), dysphagia, contracture of muscles in both lower legs, and stiffness in the left shoulder, right elbow, wrist (unspecified), and right hand.</p> <p>During a review of Resident 6's Minimum Data Set (MDS- resident assessment tool), dated 10/16/2024, the MDS indicated Resident 6 did not have any speech, was never/rarely understood, never/rarely understood others, and was severely impaired for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for toileting, showering, dressing, personal hygiene, rolling to either side in bed, and chair/bed-to-chair transfers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's Physician Order Summary Report, the Order Summary Report indicated an order was placed on 10/1/2020 for gastrostomy tube ([GT]- a tube inserted through the wall of the abdomen directly into the stomach) care, to cleanse daily with normal saline, pat dry and cover with a T-drain sponge (type of dressing) then secure with tape.</p> <p>During a review of Resident 6's care plan titled Risk for skin infection and skin breakdown initiated 9/17/2024, the care plan interventions for Resident 6 included monitoring for signs and symptoms (s/s) of infection.</p> <p>During an observation on 11/12/2024 at 2:46 p.m., in Resident 6's room, Treatment Nurse (TN) 1 was observed changing a GT dressing without performing hand hygiene after removing the dirty dressing and cleaning the site and before applying the clean dressing to the gastrostomy tube site.</p> <p>During an interview on 11/12/2024 at 3:08 p.m., with TN 1, TN 1 stated she did not perform hand hygiene after handling the dirty dressing and before applying the clean dressing to the gastrostomy tube site. TN 1 stated she should have performed hand hygiene for infection control and not doing so could cause Resident 6 to develop an infection.</p> <p>During an interview on 11/15/2024 at 12:15 p.m., with the Director of Nursing (DON), the DON stated hand washing should occur when changing a dressing, between handling the dirty and clean dressing. The DON stated, if hand washing does not occur, it could cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and lead to an infection for the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 9/19/2023, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors and the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>45269</p> <p>b. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease(COPD- group of lung diseases that block airflow and makes it difficult to breathe),end stage renal disease(ESRD-irreversible kidney failure), spinal stenosis(narrowing of spinal column that puts pressure on the spinal cord and nerve roots), and diabetes mellitus(DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 had an intact cognition (ability to think, understand, learn, and remember) and required substantial/ maximal assistance (helper does more than half the effort) with toileting hygiene, chair/bed transfer.</p> <p>During a review of Resident 22's Care Plan titled Actual infection of multidrug resistant organism (MDRO-microorganism that is resistant to a lot of antibiotics and antifungals and difficult to treat) such as C. Auris and MRSA initiated on 8/2024 and revised on 11/15/2024, the Care Plan's interventions included maintaining Contact Precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 22's General Acute Hospital Record (GACH) laboratory Results, GACH Records indicated Resident 22 had MRSA on the wound dated 10/17/2024 and C. Auris in the urine dated 4/17/2024.</p> <p>During a concurrent observation and interview on 11/14/2024, at 12:21 p.m., in Resident 22's room, observed Maintenance Supervisor (MS) and [NAME] President Resource (VPR) entered Resident 22's room without wearing a Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and practiced hand hygiene after leaving the room. VPR stated she did not look at the Contact Precaution signage posted on the door and was checking the curtains of Resident 22's room. VPR stated if the resident was on Contact Precautions, PPE should be worn.</p> <p>During an interview on 11/15/2024, at 12:27 p.m. with Director of Nursing (DON), the DON stated Resident 22 was on dialysis and had a dialysis catheter. The DON stated Resident 22 was on Vancomycin (antibiotic used to treat MRSA) during dialysis and verified through record review of Resident 22's electronic chart Resident 22 was on Contact Precautions. The DON stated the staff should practice hand hygiene, wear PPE such as gown, gloves, and mask before entering resident's room and then discard the PPE inside the room and wash hands before leaving the room to prevent spread of infection.</p> <p>During a concurrent interview and record review on 11/15/2024, at 2:13 p.m. with Infection Preventionist Nurse (IPN), reviewed Resident 22's GACH records. IPN stated Resident 22 was on Contact Precautions for an actual MRSA and extended spectrum beta-lactamase (ESBL- enzyme produced by some bacteria making them resistant to many antibiotics and are difficult to treat) infection. IPN verified thru record review Resident 22 had MRSA infection from a wound culture. IPN stated the staff should perform hand hygiene, wear gown, gloves, and mask before entering the resident's room and should remove the PPE inside the room and perform hand hygiene. IPN stated it was important to observe and practice contact precautions to prevent the spread of the infection throughout the facility.</p> <p>During a review of facility's P&P titled Isolation-Categories of Transmission -Based Precautions revised 9/2022, the P&P indicated Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. The P&P indicated staff and visitors wear gloves, disposable gowns upon entering the room and remove before leaving the room.</p> <p>36943</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During an observation on 11/15/2024 at 10:28 a.m., in soiled linen area of the laundry room, Laundry Assistant 1 (Laundry 1) wore a long-sleeve gown and nitrile gloves (typical medical gloves) to place soiled linen from a gray bin into the washer. Laundry 1 was observed removing dirty incontinence briefs from the soiled linen and placed them into the trash can. Laundry 1 did not wear any eye protection. Laundry 1 removed the long-sleeve gown overhead since it was fastened loosely around the neck and hung it on a hook next to the washer. Laundry 1 threw away both nitrile gloves into the trash can. Laundry 1 did not perform hand hygiene prior to putting on another pair of nitrile gloves. Laundry 1 left the soiled laundry area pushing the gray bin, which had wheels attached to the bottom, toward the back exit door. Laundry 1 exited the facility into the back parking lot where multiple soiled linen carts were observed. Laundry 1 removed the plastic bags from the soiled linen carts, tore the bags open, and dumped the soiled linen into the gray bin. Laundry 1 placed new plastic bags into the soiled linen cart. Laundry 1 did not perform hand hygiene after dumping the soiled linen into the gray bin and prior to placing new bags into the soiled linen carts. Laundry 1 pulled the gray bin back into the facility and entered the soiled linen area of the laundry. Laundry 1 removed both nitrile gloves and washed hands in the sink. Laundry 1 put on a new pair of nitrile gloves, placed the tied portion of the long-sleeve gown overhead, and placed both arms in the sleeves of the gown. Laundry 1 did not tie the back of the long-sleeve gown around the waist. Laundry 1 removed the soiled linen from the gray bin and placed them into the washer. Laundry 1 was observed removing incontinence briefs from the soiled linen and placed them in the trash can. Laundry 1's gown was observed moving forward from Laundry 1's body as Laundry 1 reached deeper into the gray bin. Laundry 1 removed the long-sleeved gown and placed it in the washer along with the soiled linen. Laundry 1 placed the nitrile gloves in the trash can and started the washing machine.</p> <p>During an interview on 11/15/2024 at 10:43 a.m. with Laundry 1, Laundry 1 stated the soiled linen was sorted inside the soiled linen room, including placing soiled incontinence briefs into the trash. Laundry 1 stated the long-sleeve gown was worn to prevent the soiled linen from touching Laundry 1's clothes. Laundry 1 stated she did not wear the long-sleeve gown in the back outside parking lot because the soiled linen was transferred from soiled linen bags into the gray bin.</p> <p>During an interview on 11/15/2024 at 2:24 p.m. with the Director of Nursing (DON), the DON stated the laundry staff needed to tie the gown around the waist to prevent the gown from moving.</p> <p>During an interview on 11/15/2024 at 2:26 p.m. with the Environment Services Supervisor (ESS) and the Environmental Services Regional Consultant (ESRC), the ESS stated Laundry 1 should have worn a long-sleeve gown when moving the soiled linen from the bags to the gray bin in the back outside parking lot. The ESS showed the PVC dipped gloves, eye goggles, and disposable face shields which were in plastic drawers in the soiled linen area. The ESRC stated the laundry staff needed to wear the eye protection, gown, and PVC dipped gloves to prevent injury from potentially sharp objects and for infection control while sorting soiled linen.</p> <p>During a review of the facility's P&P titled, Laundry Initiative Module 2: The Six-Step Laundry Process, revised 8/2024, the P&P indicated laundry staff should ensure use of the proper PPE while sorting soiled linen, including PVC dipped gloves, neoprene apron, and face shield. The P&P also indicated to always dump the [soiled linen] bag into a bin or barrel to sort the linen and remember to always use the proper PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. During an observation on 11/15/2024 at 8:26 a.m. in the clean linen area of the laundry room, Laundry 1 placed folded blankets from the folding table and placed in them in a wired laundry basket with wheels and exited the clean laundry area to deliver them to the clean linen carts.</p> <p>During an observation on 11/15/2024 at 12:00 p.m., in the hallway, Laundry 1 was observed transporting clean linen to a linen cart in the hallway using the wired laundry basket. The wired laundry basket was observed to have a metal clothing rack with metal bars attached to both sides of the laundry basket. There was a sheet covering the clean linen, but the sides of the wired cart were not covered, allowing the clean linen to be visible.</p> <p>During an interview on 11/15/2024 at 2:26 p.m. with the ESS and ESRC, the ESS stated the laundry staff used the wired basket to deliver clean linen to carts in the hallway during the afternoon. The ESS stated the clean linen should be covered with a sheet during transport from the clean linen room to the hallway. The ESRC stated the sides of the wired cart would be exposed despite being covered with the sheet due to the presence of the metal bars. The ESRC stated the clean linen should be fully covered for infection control purposes.</p> <p>During a review of the facility's P&P titled, Laundry Initiative Module 2: The Six-Step Laundry Process, revised 8/2024, the P&P indicated All clean linen must be covered using a clean cover during deliver to prevent potential cross contamination.</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>49145</p> <p>Based on interview and record review, the facility failed to implement antibiotic stewardship program (measures used by the facility to ensure antibiotics [drug to treat infection] for one of three residents (Resident 25).</p> <p>This failure had the potential to put Resident 25 at risk for antibiotic resistance (not effective to treat infection) and inappropriate use of antibiotic.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility 4/19/2022 with diagnoses including diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing) and cerebral infarction (a part of the brain has been damaged because it wasn't getting enough blood supply).</p> <p>During a review of Resident 25's Minimum Data Set ([MDS]- a resident assessment tool), the MDS indicated Resident 25 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent with bathing, toileting, and transferring.</p> <p>During a review of Resident 25's Antibiotic Surveillance Data Collection dated 10/17/2024, the Antibiotic Surveillance Data Collection indicated Resident 25 did not have the LOEB's criteria (set of guidelines used by healthcare providers in for long term care facilities to determine when a resident likely has a significant infection and needs antibiotics based on symptoms) indicating antibiotic use.</p> <p>During a concurrent interview and record review on 11/15/2024 at 9:32 a.m., with the Infection Prevention Nurse (IPN), the IPN stated Resident 25 was prescribed Ciprofloxacin (medication to treat a bacterial infection) but did not meet the LOEBS criteria. IPN stated Resident 25 was prescribed Keflex (medication to treat infection) from 10/17/24 to 10/24/2024 and then Ciprofloxacin from 10/29/2024 to 11/5/2024. IPN stated she spoke with Resident 25's primary physician that ordered the antibiotic and he still wanted the resident to receive the Ciprofloxacin despite not meeting the criteria. IPN stated she did not reach out to the facility's Medical Director (MD), and should have done so, to inform him Resident 25 did not meet the criteria for antibiotic use.</p> <p>During an interview on 11/15/2024 at 12:17 a.m., with the Director of Nursing (DON), the DON stated Resident 25 should not have been prescribed Ciprofloxacin because he did not meet the LOEBS criteria. The DON stated the MD should have been involved. The DON stated unnecessary medications like use of antibiotics can cause antibiotic resistance.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated 9/18/2023, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.</p> <p>(continued on next page)</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, dated 9/18/2023, the P&P indicated, As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist (IP). The IP will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are consistent with the appropriate use of antibiotics.</p> <p>Cross Reference F757</p>		

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER The Earwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145</p> <p>Based on observation, interview, and record review, the facility failed to ensure four out of 40 resident rooms measured at least 80 square feet ([sq. ft.] - unit of area equal to a square foot long on each side) per resident in multiple resident rooms. Rooms one and 23 house two residents per room and Rooms two and four housed four residents per room.</p> <p>This deficient practice had the potential to result in inadequate nursing care to the residents.</p> <p>Findings:</p> <p>During an observation on 11/12/2024 at 9:30 a.m., the following rooms were observed, Rooms one, two, four, and 23 did not meet the requirement of 80 square feet per resident.</p> <p>During a concurrent observation and interview on 11/12/2024, at 3:32 p.m., in Resident 37's room, Resident 37's bed was near the closet area with a small space in between the closet and resident's bed. Resident 37 stated he hated the small living space of the room because it affected his mobility especially when the staff member would provide care to his roommate because they would occupy the space where his wheelchair was located causing him to be moved to the side of the bed. Resident 37 stated he could not get into his closet easily because of the small space in between the bed and closet and he was not offered a room change for his concern. Resident 37 stated he would not be able to get out of his room easily if there was an emergency in the facility.</p> <p>During a review of the Client Accommodations Analysis Form provided by the Maintenance Supervisor (MS) on 11/14/2024, the Client Accommodations Analysis Form indicated.</p> <p>Rooms 1 measures 142 sq ft occupied by two residents.</p> <p>room [ROOM NUMBER] measures 154 sq. ft. occupied by two residents.</p> <p>room [ROOM NUMBER] and room [ROOM NUMBER] measures 295 sq. ft. occupied by four residents.</p> <p>During a review of the facility's request for waiver of room size letter dated 11/27/2024 submitted by ADM, for four resident rooms was reviewed. The waiver request letter indicated, These room are in accordance with the special needs of the residents and will not adversely affect resident's health and /or safety.</p>		