

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2025
NAME OF PROVIDER OR SUPPLIER  Torrance Care Center West, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  4333 Torrance Blvd Torrance, CA 90503	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 2 and 3) were free from physical abuse when Resident 1, who had a history of schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (excessive worry and feelings of fear, dread, and uneasiness), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest), suddenly without any provocation, hit Resident 2 on the left side of his face and then proceeded to hit Resident 3 on the right side of his face causing Resident 3 to fall to the floor. Resident 1 was arrested by the local area police. These deficient practices resulted in Resident 2 being transferred to a General Acute Care Hospital (GACH 1) where he was assessed with facial fractures (break in the bone) and Resident 3 being transferred via 911 (emergency services) to GACH 2 where he was treated for facial lacerations that required stitches. Findings During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) MDD and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/23/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired (a level of cognitive decline where individuals experience noticeable difficulties with memory, language judgement, and problem-solving, impacting their ability to manage daily activities independently). The MDS indicated Resident 1 required set up or clean up assistance (helper sets up or cleans up; resident completes activity) to complete activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Psychiatric Evaluation dated 6/24/2025, the Psychiatric Evaluation indicated Resident 1 presented with heightened psychomotor agitation (a state of increased physical activity and restlessness, often accompanied by mental distress or inner tension), marked anxiousness, irritability, uncooperativeness, guarded demeanor (a manner of behavior that is cautious, reserved, and restrained, often indicating a reluctance to [NAME] one's true feelings or thoughts) and restlessness. During a review of Resident 1's Change in Condition (COC) Evaluation dated 6/29/2025, the COC Evaluation indicated Resident 1 without any reason, suddenly hit a resident (Resident 3) who was walking in the hallway. The COC Evaluation indicated Resident 3 was hit on his face causing bleeding to his mouth. The COC Evaluation indicated Resident 1 was redirected to his room and away from others but continued to be physically violent to others. The COC Evaluation indicated 911 was called and Resident 1 was closely watched/guarded by male staff until the local police department arrived at the facility. During a review of Resident 1's Nursing Note dated 6/29/2025, the Nursing Note indicated Resident 1 was taken into custody by a local area police department. During a review of Resident 2's Face Sheet, the Face Sheet, indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of paranoid schizophrenia (a chronic mental health disorder characterized by persistent delusions (having false or unrealistic beliefs), hallucinations (to see, hear, feel, or smell something that does not exist), and paranoia (an extreme fear and distrust of others). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired The MDS indicated Resident 2 required supervision or touch assistance (helper provides verbal cues and or touching/steadying and/or contact guard assistance as resident completes activity) to complete his ADLs. During a review of Resident 2's COC Evaluation dated 6/29/2025, the COC Evaluation indicated Resident 2 was walking in the hallway when Resident 1 suddenly hit him on his left cheek without any provocation. The COC Evaluation indicated Resident 2's skin below his left eye was discolored, an ice pack was applied, neuro checks were initiated, and Resident 2 was closely monitored. During a review of Resident 2's physician order dated 6/29/2025, the physician order indicated to transfer Resident 2 to a GACH for further evaluation. During a review of Resident 2's Face Sheet, from GACH 1, the Face Sheet indicated Resident 2 was admitted to GACH 1 on 6/30/2025, after being transferred from GACH 2's emergency room (ER) where he was initially transported after the assault on 6/29/2025. During a review of Resident 2's GACH 1 Department of Emergency Medicine History of Present Illness, dated 6/30/2025, the History of Present Illness indicated Resident 2 was transferred from GACH 2 following an assault. The report indicated a Computed Tomography Scan (CT scan) medical imaging that uses x-rays (a form of</p>		