STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055952	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrance Care Center West, Inc	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the Responsible Party (RP) of one of four sampled residents (Resident 1) when a cup containing hot water was placed on Resident 1's overbed table (a mobile, height-adjustable table with a narrow, rectangular top designed to slide over a bed or chair) and the cup of hot water fell on Resident 1's leg causing a second degree burn (damage to the epidermis [top layer of the skin] and part of the dermis [underlying layer] causing painful, red, blistered, and swollen skin) to Resident 1's right lateral (outside) leg. This deficient practice resulted in Resident 1's RP being unaware that Resident 1 sustained a burn injury on 12/28/2025 until 1/5/2026 (eight days after the injury), the inability of the RP to participate and make decisions in Resident 1's immediate care needs and the potential for the RP to continue to be uninformed regarding Resident 1's health status.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnosis of Parkinson's disease. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/21/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired (a stage between normal age-related cognitive decline and dementia [progressive loss of memory], characterized by noticeable, measurable memory or thinking problems). During a review of Resident 1's Nursing Note dated 12/28/2025, the Nursing Note indicated Resident 1 sustained a thermal burn (an injury caused by exposure to heat sources such as hot liquids, steam, fire, or hot objects) to his right forearm (this documentation was found to be incorrect, and this injury described a burn to Resident 1's right leg not his right forearm) after an accidental spill of hot tea. The Nursing Note indicated the burned area was noted with erythema (redness) and superficial skin peeling that was consistent with a partial thickness burn (a skin injury that damages both the epidermis and dermis). During an interview on 2/10/2026 at 1:25 p.m., Licensed Vocational Nurse (LVN) 1 stated he did not get a chance to notify Resident 1's RP regarding Resident 1's burn injury but stated he endorsed Resident 1's injury status to a charge nurse on the 3 p.m., to 11 p.m., shift, whose name he could not remember. During an interview on 2/11/2026 at 12:33 p.m., Registered Nurse (RN) 1 stated LVN 1 reported to her that Resident 1 sustained a burn injury but stated she was unaware that Resident 1's RP had not been notified by LVN 1 and she (RN 1) had not notified Resident 1's RP. During an interview on 2/11/2026 at 2:33 p.m., the Administrator (ADM) stated she received a telephone call from Resident 1's RP on 1/5/2026, and the RP was frustrated because she had not been informed by the facility regarding Resident 1's burn injury. The ADM said she was unaware that Resident 1's RP had not been notified of Resident 1's burn injury that occurred on 12/28/2025. During a review of the facility's Policy and Procedure (P/P) titled Change in a Resident's Condition or Status dated 4/2011, the P/P indicated the Nurse Supervisor/Charge Nurse will notify the resident's family or (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) who was diagnosed with Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) did not sustain a second degree burn (damage to the epidermis [top layer of the skin] and part of the dermis [underlying layer] causing painful, red, blistered, and swollen skin) to his right leg. On 12/28/2025, Certified Nursing Assistant (CNA) 1 placed a lunch tray containing a cup of hot water on Resident 1's overbed table (a mobile, height-adjustable table with a narrow, rectangular top designed to slide over a bed or chair) and the cup of hot water fell onto Resident 1's right leg. The facility failed to: 1. Ensure CNA 1 considered Resident 1's risk factors related to Parkinson's disease including tremors, poor coordination and impaired mobility before placing a cup of hot water in close proximity to him. 2. Ensure hot liquids were not placed within reach of Resident 1 and left unattended, when Resident 1 had known tremors and impaired mobility related to his Parkinson's diagnosis. This deficient practice resulted in Resident 1 sustaining a second degree burn to his right leg and had the potential for a more serious injury to occur.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnosis of Parkinson's disease. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/21/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired (a stage between normal age-related cognitive decline and dementia [progressive loss of memory], characterized by noticeable, measurable memory or thinking problems) and he required substantial/maximal assistance (helper does more than half the effort) from facility staff to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident complete activity) with eating. During a review of Resident 1's Nursing Note dated 12/28/2025, the Nursing Note indicated Resident 1 sustained a thermal burn (an injury caused by exposure to heat sources such as hot liquids, steam, fire, or hot objects) to his right forearm (this documentation was found to be incorrect, and this injury described a burn to Resident 1's right leg not his right forearm) after an accidental spill of hot tea. The Nursing Note indicated the burned area was noted with erythema (redness) and superficial skin peeling that was consistent with a partial thickness burn (a skin injury that damages both the epidermis and dermis). During a review of Resident 1's Change of Condition (COC) Note dated 1/13/2026, the COC indicated Resident 1 sustained a thermal burn to his right lateral (outer area) leg after an accidental spill of hot tea. The COC indicated the affected area was red with superficial skin peeling consistent with a partial-thickness burn. There was no active bleeding or drainage noted. Resident 1 complained of pain and discomfort to the affected area. During a review of Resident 1's Physician's Order dated 12/28/2025, the Physician's Order indicated to cleanse Resident 1's thermal burn injury to his right lateral lower leg with normal saline (a sterile solution used to cleanse wounds), pat dry, apply triple antibiotic ointment (a medicated ointment used to prevent and treat skin infections cause by small cuts, scrapes, or burns), and to leave open to air every day for one month. During a review of Resident 1's Podiatrist note dated 12/31/2025, the Podiatrist note indicated the dermal layer (the skin layer underneath the outer layer) of Resident 1's right lateral leg had sloughed (peeling of larger sheets of skin due to damage) off with no active drainage. The Podiatrist note indicated the burn (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on Resident 1's leg was classified as a second-degree burn. During an interview on 2/10/2026 at 1:25 p.m., Licensed Vocational Nurse (LVN) 1 stated CNA 1 reported to him that hot tea spilled on Resident 1, he (LVN 1) went to see what happened and noted a blanket covering Resident 1's legs, a cup on top of the blanket and when he touched the blanket it was wet and warm. LVN 1 stated Resident 1's right leg had a fresh red wound with peeling skin. During a telephone interview on 2/10/2026 at 2:08 p.m., and a subsequent telephone interview on 2/11/2026 at 1:36 p.m., CNA 1 stated Resident 1 experienced frequent shaking in his upper extremities (arms) and required a lot of assistance when eating, and Resident 1 could not bring a utensil or a cup to his mouth by himself. CNA 1 stated she placed Resident 1's lunch tray on his overbed table and placed the overbed table halfway over the resident's legs close to his knees (12/28/2025), then proceeded to assist Resident 5 (Resident 1's roommate) with his lunch tray. CNA 1 stated when she put Resident 5's lunch tray down she saw the cup of hot water falling from Resident 1's lunch tray and tried to grab the cup, but she could not catch the cup before it fell on Resident 1. CNA 1 stated she did not know how the cup of hot water fell but stated she should not have placed Resident 1's lunch tray with hot water so close to Resident 1 because he could have grabbed the cup and caused it to fall. During an interview on 2/11/2026 at 11:39 a.m., the Podiatrist (PD) stated it was obvious the burn to Resident 1's right lateral leg was caused by hot water because the epidermis and dermal layers were affected. During an interview on 2/11/2026 at 2:12 p.m., the Director of Nursing (DON) stated the use of Resident 1's fine motor skills (the coordination of small muscles, typically in the hands and fingers, with the eyes [hand-eye coordination) to perform precise, small-scale movements) were limited and his lunch tray should have been placed on his overbed table next to him just before CNA 1 fed him and not left unattended because there were hot items on the tray. During a review of the facility's undated Policy and Procedure (P/P) titled Accidents and Supervision, the P/P indicated staff were required to observe and identify potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 accurately documented in the clinical record for one of four sampled residents (Resident 1) when Resident 1 sustained a thermal burn (an injury caused by exposure to heat sources such as hot liquids, steam, fire, or hot objects) to his right lateral (on the outside) leg, but documentation indicated Resident 1's right forearm. This deficient practice resulted in the inaccurate documentation of Resident 1's status and had the potential for confusion and non-continuity of care.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnosis of Parkinson's disease. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/21/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired (a stage between normal age-related cognitive decline and dementia [progressive loss of memory], characterized by noticeable, measurable memory or thinking problems). During a review of Resident 1's Nursing Note dated 12/28/2025, the Nursing Note indicated Resident 1 sustained a thermal burn to his right forearm (this documentation was found to be incorrect, and this injury described a burn to Resident 1's right leg not his right forearm) after an accidental spill of hot tea. The Nursing Note indicated the burned area was noted with erythema (redness) and superficial skin peeling that was consistent with a partial thickness burn (a skin injury that damages both the epidermis and dermis). During a review of Resident 1's Change of Condition (COC) note dated 1/13/2026 (the correct date of the COC and Resident 1's burn injury should have been 12/28/2025), the COC indicated Resident 1 sustained a thermal burn to his right lateral leg after an accidental spill of hot tea. During a telephone interview on 2/10/2026 at 1:25 p.m., LVN 1 stated an audit was conducted (1/13/2026) and his nursing note was flagged because he documented Resident 1's burn injury to his right forearm when it should have been documented as his right lateral leg. LVN 1 stated he was instructed to correct the documentation (1/13/2026) and he could not figure out how to change Resident 1's COC note, which was initially dated 12/28/2025, so he created a new COC note dated 1/13/2026. During an interview on 2/11/2026 at 2:12 p.m., the Director of Nurses (DON) after reviewing Resident 1's Nursing Note dated 12/28/2025 and Resident 1's COC note dated 1/13/2026 stated, LVN 1's documentation made it appear as if Resident 1 had two different burn injuries. The DON stated LVN 1 should have made a late entry note to correct the inaccurate documentation of Resident 1's burn injury and to correct the date of Resident 1's COC note. During a review of the facility's undated Policy and Procedure (P/P) titled Charting and Documentation the P/P indicated documentation or procedures and treatments shall include care-specific details and shall include at a minimum the date and time the procedure/treatment was provided and the assessment data and/or any unusual findings obtained during the procedure/treatment.