

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/08/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had chronic pain (pain that lasts longer than three months) and who had an order for a Transcutaneous Electrical Nerve Stimulation ([TENS] a non-invasive pain relief therapy that uses a compact, battery-powered device to send mild, low-voltage electrical currents through the skin), had the order clarified. This failure resulted in an eight-day delay in clarifying information and implementing a physician-ordered pain management intervention for Resident 1. This failure had the potential for Resident 1 to experience increased pain or discomfort, decreased mobility, sleep disturbances from uncontrolled pain, increased use of pain medications, and a decline in quality of life and emotional well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 was admitted with diagnoses including intervertebral disc disorders with radiculopathy, lumbar region (a worn or damaged disc, pressing on a nerve causing sharp pain, tingling, numbness or weakness to the lower back), spondylosis (inflammation of the joints between the bones of the spine), myalgia (muscle pain), and muscle spasms (an involuntary muscle contraction; can sometimes be powerful and painful). During a review of Resident 1's History and Physical (H&P) dated 4/29/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and supervision (helper provides verbal cues and/or touching/steadying assistance) from staff for toileting, dressing, shower/bathing and personal hygiene. The MDS indicated Resident 1 received scheduled pain medications regimen and received non-medication intervention for pain. During a review of Resident 1's Pain and Rehabilitation Medical Group Progress Note dated 5/12/2026, the Progress Note indicated Resident 1 was seen by the pain management physician for follow-up related to bilateral low back pain and thoracic back pain and had been utilizing an adaptive TENS unit. The Progress Note indicated Resident 1 was to continue the current treatment plan and the utilization of the adaptive TENS unit. During a review of Resident 1's Interdisciplinary Team (IDT) Meeting/Care Conference Note dated 5/26/2026, the IDT Note indicated the IDT met with Resident 1 on 5/26/2026 regarding the TENS equipment, that Resident 1 was informed there was physician order in place for the TENS equipment and nursing would follow-up with the pain management physician who approved the TENS unit. The IDT Note further indicated Resident 1 was made aware the patches for the TENS unit would be given to the resident once nursing received a physician order with proper instruction to use the device under supervision. The IDT Meeting Care Conference note indicated Resident 1 would be notified when nursing received the order. During a review of Resident 1's Pain and Rehabilitation Medical Group Facsimile Transmittal Sheet dated 5/27/2026, the Sheet indicated the facsimile was sent to the facility and addressed to the Director of Nursing (DON). The facsimile transmittal sheet notes/comments section indicated, Rx (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055952	Facility ID: 055952 If continuation sheet Page 1 of 8

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 06/08/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(prescription) for TENS unit, Report attached. The facsimile header indicated the documentation was faxed from Pain and Rehabilitation Medical Group on 05/27/2026 at 1:39 p.m., and received on 5/27/2026 at 2:29 p.m. The prescription attached to the facsimile transmittal indicated Resident 1 to use the TENS unit as directed. During a concurrent observation, interview, and record review on 6/4/2026 at 12:23 p.m., with Resident 1, while in Resident 1's room, Resident 1's facsimile for TENS unit order on 5/27/2026 from the pain management physician was reviewed. Resident 1 was observed retrieving his TENS unit from his bedside drawer and stated his pain management physician instructed him to use the device for pain relief. Resident 1 stated the Director of Nursing (DON) informed him additional paperwork would be required before he could use the TENS unit. Resident 1 stated the pain management physician's order indicated to use the device TENS unit whenever he needed it for pain, but the DON informed him she required an order specifying exact times, settings, and frequency of use. Resident 1 stated the DON directed him to call the prescribing pain management physician to obtain a revised order, however, the pain management physician was on vacation at that time. Resident 1 stated he continued using the device as needed for pain, but the DON told him she did not want him to use the device until she received the revised order. Resident 1 stated he called his pain management physician, and the physician sent another order permitting use of the TENS unit whenever he needed, but the DON continued to tell him a more specific order was required. Resident 1 stated the DON later told him he was permitted to use the TENS unit during the day and night but continued to request detailed parameters for the TENS unit from the resident's pain management physician. Resident 1 stated he received instruction on how to use the device at his pain management physician's office and was connected to a liaison from the manufacturer of the TENS unit to monitor the device use remotely. Resident 1 provided a copy of the pain management physician order, which was faxed from the office on 5/27/2026, and indicated the device should be used as directed. Resident 1 stated his physician instructed him to use the TENS unit whenever he experienced pain and adjust the intensity to a level that relieved his pain. Resident 1 stated the TENS unit would automatically shut off after 60 minutes. Resident 1 stated his physician informed him he could not provide a set schedule for use because the frequency and intensity set on the TENS unit depended on his pain level. During a review of Resident 1's Nursing Progress Notes dated 5/15/2026 through 6/3/2026, the Progress Notes contained no entries indicating receipt of the TENS unit order, no documentation of attempts to clarify the TENS unit order, and no documentation of implementing or monitoring the TENS unit during this period. During a concurrent interview and record review on 6/4/2026 at 1:16 p.m., with LVN 1, Resident 1's Nursing Progress Notes and TENS unit facsimile order dated 5/27/2026 was reviewed. LVN 1 stated she received appointment information from social services, and that the pain management office sometimes called the facility to schedule follow-up appointments and sometimes sent paperwork back with the resident. LVN 1 stated she first became aware of the TENS unit order on 6/4/2026, when the DON gave her a new order for the TENS unit that was faxed from the pain management physician's office. LVN 1 reviewed Resident 1's original TENS unit order dated 5/27/2026 and stated the original order required clarification. LVN 1 stated the facility received clarification of the TENS unit order on 6/4/2026. LVN 1 stated when a physician order required clarification, nursing staff should document the clarification request in the nursing progress notes. LVN 1 reviewed the Nursing Progress Notes dated 5/27/2026 to 6/3/2026 and acknowledged there were no entries documenting any attempt to clarify the TENS order during that period. LVN 1 stated the DON had been working on obtaining the clarification but may have forgotten to document the clarification process in the progress notes. LVN 1 stated the DON informed her she entered the clarification order for the TENS device on 6/4/2026, and she was unsure when the DON initially contacted the pain management physician's office for clarification. LVN 1 retrieved a copy of the clarified TENS order dated 6/4/2026 and stated the delay in obtaining the clarified order might have occurred because the order could have been left on the fax machine. LVN 1 stated that clarification of physician orders should be completed promptly, and that an eight-day delay did not (continued on next page)		

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 06/08/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow expected practice. LVN 1 stated timely clarification was important so that the resident could receive prescribed treatment, and that the TENS device was part of the resident's pain management regimen. During a telephone interview on 6/4/2026 at 4:12 p.m., with the Medical Director/Primary Care Physician (MD/PCP), the MD/PCP stated he served as the facility's Medical Director and Resident 1's primary care physician. The MD/PCP stated anything ordered in the facility was required to go through him. The MD/PCP stated he did not recall Resident 1 by name but stated if nursing staff contacted him; he would have written an order for Resident 1 to use the TENS device regularly at least three times per day. The MD/PCP stated the Physical Therapy (PT) Department would have assisted Resident 1 with education of the TENS unit and adjustment of the device's intensity (strength of the electrical sensation produced by the TENS device). The MD/PCP stated when the facility received an order from a pain management physician, the nursing staff were expected to call him so he could issue treatment orders and ensure PT provided training. The MD/PCP stated if the TENS order arrived on 5/27/2026, the nursing staff should have contacted him on 5/27/2026 to obtain treatment orders. During an interview on 6/5/2026 at 9:50 a.m., with the Physical Therapist (PT), the PT stated Resident 1 placed the TENS device on himself and adjusted the intensity. The PT stated the resident had the TENS unit equipment before the order on 6/4/2026. The PT stated she went to Resident 1's room before 6/4/2026 to provide initial instructions. The PT stated the DON asked her to go over the equipment with the resident because the DON was very worried about Resident 1 having the TENS unit in his possession. During an interview on 6/5/2026 at 10:30 a.m., with the DON, the DON stated she saw the TENS unit order on the fax machine on 6/4/2026 and entered the order into Resident 1's electronic health record. The DON stated nursing staff attempted to contact the pain management physician for clarification of the TENS unit order and left messages but had not received a call back. The DON stated she did not remember the dates of the calls and did not document the attempts. The DON stated nursing staff was responsible for initiating clarification of orders and documenting attempts to clarify orders in the Nursing Progress Notes. The DON stated if nursing staff could not reach a physician to clarify an order, nursing staff was required to escalate the concern to the MD. The DON stated there were no progress notes with documented attempts to contact the pain management physician or documented escalation to the MD when the pain management physician could not be reached. The DON stated orders should have been initiated and clarified the same day, and the TENS unit should have been addressed right away. The DON stated not following through with order clarification in a timely manner could cause more pain for the resident due to the delay in treatment and could cause frustration for the resident. The DON stated she should have documented the notification attempts to the physician, so nursing staff would have a trail of what had been done for Resident 1 and what had been addressed regarding the TENS unit order and Resident 1's pain. The DON stated when orders were not addressed in a timely manner, it delayed care and could affect the quality of care for the resident. During a review of the facility's undated policy and procedure (P&P) titled, Medical Devices Protocol and Policy, the P&P indicated the policy applied to facility-owned, leased, rented, physician-ordered, therapy-issued, and resident-owned medical devices used within the facility, including TENS units. The P&P indicated the facility would ensure all medical devices were supported by physician orders when clinically indicated, incorporated into the resident's plan of care when applicable, and monitored for adverse events and safety concerns. The P&P indicated devices requiring a physician order would not be initiated without written authorization from the attending physician or other authorized practitioner. The P&P indicated orders would include clinical indication, frequency of use, duration of use, specific settings when applicable, and monitoring parameters. The P&P indicated prior to and during device use, staff would assess clinical need, resident response, skin integrity when applicable, pain or discomfort, device placement, functionality and alarms, and signs of complications. The P&P indicated staff would document physician orders, device initiation, resident education, device settings, monitoring performed, and resident response. During a review of the facility's undated P&P, titled, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/08/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Order Clarification, the P&P indicated the facility would ensure all physician orders were complete, accurate, clinically appropriate, and implemented as intended by the ordering practitioner. The P&P indicated any physician order that was incomplete, unclear, ambiguous, conflicting, or potentially unsafe would be clarified with the ordering practitioner prior to implementation whenever possible. The P&P indicated the receiving licensed nurse would obtain clarification whenever an order contained incomplete treatment instructions, unclear parameters, questionable frequency or duration, incomplete treatment orders, or any order that could not be safely implemented as written. The P&P indicated the nurse would contact the ordering physician or authorized practitioner as soon as possible to obtain clarification. The P&P indicated clarification activities would be documented in the medical record, including the date and time of clarification, name of practitioner providing clarification, clarified order, and name and credentials of the nurse receiving clarification.		

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 06/08/2026
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had chronic pain (pain that lasts longer than three months), that their pain was managed. The facility failed to:1. Monitor Resident 1's pain at least every shift.2. Assess Resident 1's pain before and after administration of pain medications.3. Implement non-pharmacological pain-management interventions (therapies and measures to control pain that do not involve taking medication) to Resident 1.4. Document ongoing pain assessments for a resident with chronic pain.This failure resulted in a lack of documented information to determine Resident 1's pain level, whether pain medications were effective, and whether non-pharmacological pain-management interventions were provided, which could delay recognition of uncontrolled pain and needed changes to Resident 1's pain-management interventions.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 was admitted with diagnoses including intervertebral disc disorders with radiculopathy, lumbar region (a worn or damaged disc, pressing on a nerve causing sharp pain, tingling, numbness or weakness to the lower back), spondylosis (inflammation of the joints between the bones of the spine), myalgia (muscle pain), and muscle spasms (an involuntary muscle contraction which can sometimes be powerful and painful). During a review of Resident 1's History and Physical (H&P) dated 4/29/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, and supervision (helper provides verbal cues and/or touching/steadying assistance) from staff for toileting, dressing, shower/bathing and personal hygiene. The MDS indicated Resident 1 received scheduled pain medications regiment and received non-medication intervention for pain. During a review of Resident 1's Medication Review Report (Physician's Orders), dated 4/28/2026, the Physician Order's indicated Resident 1 was to receive the following medications:1. Oxycodone-Acetaminophen ([Percocet] an opioid [medication to relieve moderate to severe pain]) 10-325 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), one tablet every eight hours for chronic muscle spasm, ordered on 4/28/2026. 2. Gabapentin (a medication used to control nerve pain) 600 mg, one tablet every eight hours for pain, ordered on 4/28/2026. 3. Tizanidine HCl ([Zanaflex] a medication used to relieve discomfort, cramping, and muscle stiffness caused by injuries, spasms, or conditions) 4 mg, one tablet three times a day for muscle spasm, ordered on 4/28/2026. 4. Cilostazol (a vascular medication specifically used to reduce leg pain or cramping caused by poor circulation in the legs) 100 mg, one tablet two times a day for intermittent claudication (leg pain or cramping that occurs during walking or exercise and goes away with rest, ordered on 4/28/2026. During a review of Resident 1's Physician's Order dated 6/1/2026 to 6/30/2026, there were no orders indicating to monitor Resident 1's pain level or to implement non-pharmacological pain interventions to Resident 1. During a review of Resident 1's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/2026 to 6/2026, there was no documentation indicating Resident 1's pain was monitored before or after he received pain medication. During a review of Resident 1's MAR dated 5/2026 to 6/2026, there was no documentation indicating Resident 1 received non-pharmacological interventions to treat his pain. During a review of Resident 1's Pain Scale Log dated 5/6/2026 to 6/4/2026, there was no documentation indicating Resident 1's pain was assessed. During a review of Resident 1's untitled Care Plan, dated 9/24/2025 and revised on 5/15/2026, the Care Plan indicated Resident 1 was at risk (continued on next page)		

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 06/08/2026
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for alteration in comfort/pain. The Care Plan interventions indicated staff were to assess pain using an appropriate pain rating scale, provide non-pharmacological interventions for pain management, administer pain medications as ordered, and notify the physician of unresolved pain. During a review of Resident 1's Pain and Rehabilitation Medical Group Progress Note dated 5/12/2026, the Progress Note indicated Resident 1 was seen by the pain management physician for follow-up related to bilateral low back pain and thoracic back pain. The Progress Note indicated Resident 1 had been utilizing an adaptive Transcutaneous Electrical Nerve Stimulation ([TENS] a non-invasive pain relief therapy that uses a compact, battery-powered device to send mild, low-voltage electrical currents through the skin) unit. The Progress Note indicated Resident 1's plan was to continue the current treatment plan, including exercise regimen and medication management, and the utilization of the adaptive TENS treatment. During a concurrent observation, interview, and record review, dated 6/4/2026 at 12:23 p.m., with Resident 1, Resident 1's facsimile for TENS unit order on 5/27/2026 from the pain management physician was reviewed. Resident 1 was observed retrieving his TENS unit from his bedside drawer and stated his pain management physician instructed him to use the device for pain relief. Resident 1 stated the Director of Nursing (DON) informed him additional paperwork would be required before he could use the TENS unit. Resident 1 stated the pain management physician's order indicated to use the device TENS unit whenever he needed it for pain, but the DON informed him she required an order specifying exact times, settings, and frequency of use. Resident 1 stated the DON directed him to call the prescribing pain management physician to obtain a revised order, however, the pain management physician was on vacation at that time. Resident 1 stated he continued using the device as needed for pain, but the DON told him she did not want him to use the device until she received the revised order. Resident 1 stated he called his pain management physician, and the physician sent another order permitting use of the TENS unit whenever he needed, but the DON continued to tell him a more specific order was required. Resident 1 stated the DON later told him he was permitted to use the TENS unit during the day and night but continued to request detailed parameters for the TENS unit from the resident's pain management physician. Resident 1 stated he received instruction on how to use the device at his pain management physician's office and was connected to a liaison from the manufacturer of the TENS unit to monitor the device use remotely. Resident 1 provided a copy of the pain management physician order, which was faxed from the office on 5/27/2026, which indicated the device should be used as directed. Resident 1 stated his physician instructed him to use the TENS unit whenever he experienced pain and adjust the intensity to a level that relieved his pain. Resident 1 stated the TENS unit would automatically shut off after 60 minutes. Resident 1 stated his physician informed him he could not provide a set schedule for use because the frequency and intensity set on the TENS unit depended on his pain level. During a concurrent interview and record review on 6/4/2026 at 1:16 p.m., with LVN 1, Resident 1's Care Plans, Nursing Progress Notes, and TENS unit facsimile order dated 5/27/2026 was reviewed. LVN 1 stated she first became aware of the TENS unit order on 6/4/2026, when the DON gave her a new order for the TENS unit that was faxed from the pain management physician's office. LVN 1 reviewed Resident 1's original TENS unit order dated 5/27/2026 and stated the original order required clarification. LVN 1 stated the facility received clarification of the TENS unit order on 6/4/2026. LVN 1 stated that when a physician order required clarification, nursing staff should document the clarification request in the nursing progress notes. LVN 1 reviewed the nursing progress notes dated 5/27/2026 to 6/3/2026 and acknowledge there were no entries documenting any attempt to clarify the TENS order during that period. LVN 1 stated the DON had been working on obtaining the clarification but may have forgotten to document the clarification process in the progress notes. LVN 1 stated the DON informed her she entered the clarification order for the TENS device on 6/4/2026, and she was unsure when the DON initially contacted the pain management physician's office for clarification. LVN 1 retrieved a copy of the clarified TENS order dated 6/4/2026 and stated the delay in obtaining the clarified order might have occurred because the order could have been left on the fax (continued on next page)		

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 06/08/2026
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine. LVN 1 stated that clarification of physician orders should be completed promptly, and that an eight-day delay did not follow expected practice. LVN 1 stated timely clarification was important so that the resident could receive prescribed treatment, and that the TENS device was part of the resident's pain management regimen. During a telephone interview on 6/4/2026 at 4:12 p.m., with the Medical Director/Primary Care Physician (MD/PCP), the MD/PCP stated he served as the facility's Medical Director and Resident 1's primary care physician. The MD/PCP stated anything ordered in the facility was required to go through him. The MD/PCP stated he did not recall Resident 1 by name but stated if nursing staff contacted him; he would have written an order for Resident 1 to use the TENS device regularly at least three times per day. The MD/PCP stated the Physical Therapy (PT) Department would have assisted Resident 1 with education of the TENS unit and adjustment of the device's intensity (strength of the electrical sensation produced by the TENS device). The MD/PCP stated when the facility received an order from a pain management physician, the nursing staff were expected to call him so he could issue treatment orders and ensure PT provided training. The MD/PCP stated if the TENS order arrived on 5/27/2026, the nursing staff should have contacted him on 5/27/2026 to obtain treatment orders. During an interview on 6/5/2026 at 9:50 a.m., with the Physical Therapist (PT), the PT stated the resident placed the TENS device on himself and adjusted the intensity. The PT stated the resident's skin needed regular checks because the device used an electrical current. The PT stated the resident was instructed to remove the device when it was not in use, not to sleep in it so his skin could breathe, and not to shower while wearing it. The PT stated if the device caused pain, the resident was instructed to turn the intensity down and call the nurse. The PT stated the resident could wear the device for a couple of hours at a time and then remove it. The PT stated the resident wore the device on his upper back, and she told him not to change the location unless he notified the nurses before changing the area. The PT stated she went to the resident before 6/4/2026 to provide initial instructions. The PT stated the resident had the equipment before the order. The PT stated she educated the resident on the equipment before 6/4/2026. The PT stated the DON asked her to go over the equipment with the resident because the DON was very worried about the resident having the TENS unit in his possession. During a concurrent interview and record review on 6/5/2026 at 10:30 a.m., with the Director of Nursing (DON), Resident 1's Pain and Rehabilitation Medical Group Progress Note dated 5/12/2026, Physician Orders, Care Plans, and MAR were reviewed. The DON stated there was no monitoring for pain ordered for Resident 1 and that pain monitoring should occur at least once per shift. The DON stated she did not see any pain monitoring for Resident 1, even though the resident had chronic pain, received routine pain medications, and was followed by a pain management physician. The DON stated the last documented pain level was on 5/6/2026 and there was no indication of the resident's pain level after that date. The DON stated when pain medications are administered, nurses must obtain a pain level before administration and must check back 45 minutes to one hour after administration to assess for effectiveness. The DON stated this was not done. The DON stated there should be a standard order for pain assessment. The DON stated pain monitoring was part of the nursing assessment and should have been charted even if there was no specific order. The DON stated pain assessments could have been documented in the progress notes, but they were not. The DON acknowledged that documented pain levels existed from 4/28/2026 to 5/6/2026 and stated there should be documented pain levels every day for every shift and before and after pain medications. The DON stated the Resident 1's Care Plan instructed staff to assess pain using an appropriate rating scale and to provide non-pharmacological interventions for pain management, but the MAR dated 5/2026 and 6/2026 did not contain non-pharmacological interventions. The DON stated without documentation of interventions there was no way to determine whether any were provided. The DON further stated the nurses were not consistently following up with the Resident's pain management physician after appointments, which resulted in a lack of pain management information, delayed care, and the facility not knowing how to manage the resident's pain. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment (continued on next page)		

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 06/08/2026
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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Management, undated, the P&P indicated the purpose of the procedure was to help staff identify pain in the resident and develop interventions that were consistent with the resident's goals and needs and addressed the underlying causes of pain. The P&P indicated pain management included assessing the potential for pain, recognizing the presence of pain, identifying the characteristics of pain, developing and implementing approaches to pain management, monitoring for the effectiveness of interventions, and modifying approaches as necessary. The P&P indicated the facility would conduct a comprehensive pain assessment upon admission, quarterly, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. The P&P indicated the facility would assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain, and at least weekly in stable chronic pain. The P&P indicated during the comprehensive pain assessment, staff would gather the history of pain and its treatment, including pharmacological and non-pharmacological interventions, intensity of pain, descriptors of pain, pattern of pain, location and radiation of pain, frequency, timing, duration of pain, factors and strategies that reduced pain, and symptoms that accompanied pain. The P&P indicated staff would assess pain using a consistent approach and standardized pain assessment instrument appropriate to the resident's cognitive level. The P&P indicated non-pharmacological interventions may be appropriate alone or in conjunction with medications and included environmental, physical, exercise, cognitive, or behavioral interventions. The P&P indicated physical non-pharmacological interventions included ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, and other interventions. The P&P indicated staff would re-assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain, and at least weekly in stable chronic pain. The P&P indicated staff would monitor the resident's response to interventions and level of comfort over time. The P&P indicated staff would document the resident's reported level of pain with adequate detail to gauge the status of pain and the effectiveness of interventions for pain. The P&P indicated staff would report significant changes in the level of the resident's pain and prolonged, unrelieved pain despite care plan interventions to the physician or practitioner. During a review of the facility's undated P&P titled, Vital Signs, the P&P indicated pain assessment was to be obtained and interpreted by licensed nurses.		