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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a vital communication tool, ensuring residents can easily alert nurses or other caregivers when they need help) was in reach and not observed on the floor for one of residents (Resident 90). This deficient practice had the potential to compromise Resident 90's ability to request staff assistance, placed the resident at risk for unmet needs, and deny Resident 90 the right to a dignified environment which could affect their health, safety, and quality of life. Findings:During a review of Resident 90's admission Record (a document containing demographic and diagnostic information) , the admission Record indicated Resident 90 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and failure to thrive (a decline which can cause weight loss, poor appetite, poor food intake). During a review of Resident 90's History and Physical (H& P) dated 9/4/2024, the H&P indicated Resident 90 had a fluctuating capacity to understand and make decisions. During a review of Resident 90's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 5/22/2025, the MDS indicated Resident 90 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). The MDS indicated assistance may be provided throughout the activity or intermittently for toileting hygiene, shower/bath, and personal hygiene. During a concurrent observation and interview on 8/12/2025 at 11:37 a.m. with Certified Nurse Assistant (CNA 2) in Resident 90's room, Resident 90's call light was located on the floor behind her bed, not within her reach. CNA 2 stated that she is responsible for ensuring the call light is always within the resident's reach. CNA 2 stated when she leaves a resident's room, she ensures the call light is within their reach. CNA 2 stated Resident 90 uses her call light for assistance and would not be able to pick her call light from the floor. CNA 2 stated the facility's policy is that call lights must always be accessible to residents to ensure their safety. During an interview on 8/12/2025 at 1:25 p.m. with License Vocational Nurse (LVN) 2, LVN 2 stated it is every staff member's responsibility to ensure that residents always have their call lights within reach. LVN 2 stated if a call light were on the floor, she would immediately return it to the residents and check if they needed assistance. LVN 2 stated Resident 90 relies on the call light for help, so it is critical that it is always within her reach. LVN 2 stated she expects the CNA's to always check for call light placement before leaving the room, and she monitors the staff for compliance during daily rounding. LVN 2 stated it is the facility's policy call lights always be accessible to the residents to ensure residents' rights, dignity, and safety. During an interview on 8/14/2025 at 2:00 p.m. with the Director of Nursing (DON), the DON stated it is the facility's policy that all residents must always have their call lights within reach. The DON stated it is the responsibility of all direct care staff CNA's, LVN's, and RNs to ensure this before leaving a resident's room. The DON stated staff are trained during orientation and reinforced in ongoing in-services about resident rights and safety, including call light accessibility. The DON stated if a call light is found on the floor, staff are expected to immediately return it to the residents and check if assistance is needed. The DON stated because Resident 90 relies on the call light for assistance and could not pick it up independently that creates a safety risk for the resident. During a review of the facility's policy and procedure (P&P) titled, Call Light Policy, [undated], the P&P indicated, Call lights are positioned so the resident/patient can easily access them from the bed, chair, or bathroom. During a review of the facility's policy and procedure (P&P) titled Promoting/Maintaining Resident Dignity, [undated], the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess mental capacity(ability to understand information and make decisions) accurately on one of four sampled residents(Resident 22) when the resident was provided an informed consent(voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered)for a psychotropic medication(any drug that affects brain activities associated with mental processes and behavior).This failure had the potential to violate Resident 22's right to be informed.Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified dementia (a progressive state of decline in mental abilities),unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and unspecified mood affective disorder(mental health condition characterized by symptoms of a mood disorder that do not fully meet the criteria for a specific named diagnosis).During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 7/7/2025, the MDS indicated Resident 22 had severely impaired cognitive (ability to think, understand, learn, and remember) skills and required supervision or touching assistance (helper provides verbal cues and contact guard assistance as resident completes the activity) with eating, oral hygiene, dressing and toileting hygiene.During a review of Resident 22's History and Physical (H&P) dated 1/17/2025, the H&P indicated Resident 22 did not have the capacity to understand and make decisions.During a review of Order Summary Report dated 1/16/2025, the Order Summary Report indicated a physician order of Divalproex Sodium (medication for patients with acute bipolar mania [a state of extremely elevated mood and energy associated] and epilepsy {disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]}) 250 milligrams(mgs.- unit of measurement)Depakote- medication that treats convulsions and stabilize mood) give one tablet by mouth two times a day for mood disorder manifested by periods of agitation (restless physical and emotional activity). The Order Summary Report indicated an informed consent was obtained by the physician from a responsible party.During a review of Resident 22's 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) Meeting Care Conference dated 7/7/2025, IDT Meeting Care Conference indicated Resident 22 was self-responsible (able to make informed choices and taking actions that promote health and prevent illness) and had no family involved in his care.During a review of Informed Consent Form for use of Divalproex 250 mgs. twice a day for mood disorder manifested by periods of agitation dated 1/16/2025, the Informed Consent Form was obtained from Resident 22 and Director of Staff Development (DSD) received the physician order. The Informed Consent Form indicated the DSD and physician signed informed consent on 1/16/2025, at 8:30 p.m. During a concurrent observation and interview on 8/11/2025, at 1:10 p.m. with Resident 22, Resident 22 was unable to answer questions appropriately when asked by the surveyor during initial screening of residents for the survey.During a concurrent interview and record review on 8/14/2025 at 11:44 a.m., with DSD, Resident 22's Informed Consent for Divalproex was reviewed. DSD stated she was responsible for doing admissions for residents in the afternoon. DSD stated Divalproex was a medication that was resumed and continued in the facility from the hospital. DSD stated she called the physician during admission day and obtained an order to continue Divalproex. DSD stated she wrote the name of Resident 22 in the Informed Consent Form because there was no responsible party. DSD admitted it was not the right way to obtain informed consent. DSD stated she should have called back the physician to inform him that Resident 22 was not mentally competent and should have referred Resident 22 to the social services to look for a family or public guardian (public official appointed by a court who serves as a conservator for individuals who are unable to care for themselves due to mental or physical condition). DSD stated not informing the resident or family representative about the use of Divalproex and not assessing resident's mental capacity before providing informed consent was not the right way to provide informed consent because it could violate resident's rights. During a concurrent interview and record review on 8/14/2025, at 11:16 p.m. and subsequent interview on 8/14/2025, at 12:25 p.m., with the Director of Nursing (DON), Resident 22's Informed Consent for Divalproex, Progress Notes and Physician Progress Notes were reviewed. The DON stated the informed consent was provided to Resident 22 for Divalproex and there was no documentation the physician was notified about

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure reasonable accommodation of needs for one of one resident (Resident 90) when staff did not make the residents' pictogram communication board (involves using simple pictures or symbols to convey important information to residents, especially those with language barriers) accessible. This deficient practice had the potential to impede Resident 90's ability to express her needs, make choices, and participate in care decisions, thereby affecting her dignity and quality of life. Findings: During a review of Resident 90's admission Record (a document containing demographic and diagnostic information), the admission Record indicated Resident 90 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and failure to thrive (a decline which can cause weight loss, poor appetite, poor food intake). During a review of Resident 90's History and Physical (H& P) dated 9/4/2024, the H&P indicated Resident 90 had fluctuating capacity to understand and make decisions. During a review of Resident 90's Minimum Data Set ([MDS] - a resident assessment tool) dated 5/22/2025, indicated Resident 90 required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for toileting hygiene, shower/bath, and personal hygiene. During a review of Resident 90's care plan, dated 11/22/2024, the Care Plan indicated the resident is at risk for impaired communication related to cognitive deficits, which impair her ability to communicate needs effectively. The care plan interventions included to Provide communication board, if applicable.During a concurrent observation and interview on 8/12/2025 at 11:37 a.m. with Certified Nurse Assistant (CNA) 2, in Resident 90's room, the resident's pictogram communication board was not found inside of the bedside table drawer and not within the resident's reach. CNA 2 stated the staff keeps the pictogram inside the drawer so it does not get misplaced, but she realizes Resident 90 cannot get it without assistance from the staff. CNA 2 stated Resident 90 could not communicate without the pictogram because she only speaks Korean. CNA 2 stated the staff rely on the pictogram to understand what the residents' needs are. CNA 2 stated Resident 90 may not be able to express pain, hunger, thirst, or toileting needs when the pictogram is left inside of the bedside table. During an interview on 8/12/2025 at 1:25 p.m. with License Vocational Nurse (LVN 2), LVN 2 stated Resident 90's pictogram should be always placed within her reach, especially since the resident uses it as their primary form of communication. LVN 2 stated she is unsure why it was put away in the drawer. LVN 2 stated the expectation is that communication devices, such as pictograms should always be accessible so residents can express their needs and preferences. LVN 2 stated Resident 90 might not be able to communicate pain, needs, or preferences, which could lead to frustration, unmet needs, delayed care, or even a decline in their overall well-being. During an interview on 8/14/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated it is the facility's policy that all residents' communication devices must be always kept within reach so they can effectively express their needs, preferences, and concerns. The DON stated if the pictogram is not accessible, the resident may not be able to communicate pain, discomfort, or basic needs. The DON stated that it could cause the residents' frustration, delayed care, unmet needs, and could negatively impact their safety and quality of life. During a review of the facility's policy and procedures (P&P) titled, Accommodation of Needs, [undated] indicated, the P&P indicated Facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment.During a review of the facility's policy and procedures (P&P) titled, Provision of Quality Care, [undated], the P&P indicated Based on comprehensive assessment, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure seven of seven sampled residents (Resident 25, Resident 29, Resident 41, Resident 58, Resident 59, Resident 96 and Resident 108) received their mail on Saturdays.This failure resulted in Resident 25, Resident 29, Resident 41, Resident 58, Resident 59, Resident 96 and Resident 108 rights violated to receive mail on Saturdays.Findings:1. During a review of Resident 25's admission Record (Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 25 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and homelessness.During a review of Resident 25's History and Physical (H&P), dated 7/16/2025, the H&P indicated Resident 25 could make needs known but could not make medical decisions. During a review of Resident 25's Minimum Data Set (MDS-a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 25 was independent with eating oral hygiene, toileting, showering, dressing, putting on and taking off footwear, and personal hygiene.2. During a review of resident 29's Face Sheet, the Face Sheet indicated Resident 29 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including lymphedema (swelling of the arms or legs due to a buildup of lymph fluid in the body's tissues), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), obesity, and arthropathy (and disease or condition that affects the joints).During a review of Resident 29's History and Physical (H&P), dated 2/20/2025, the H&P indicated, Resident 29 had the capacity to understand and make decisions.During a review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 needed partial to moderate assistance from nursing staff with showering, putting on and taking off footwear, and walking. The MDS indicated Resident 29 needed supervision or touching assistance from nursing staff with toileting, lower body dressing, personal hygiene, and transferring. The MDS indicated Resident 29 was independent with eating, oral hygiene, and upper body dressing.3. During a review of Resident 41's Face Sheet, the Face Sheet indicated, Resident 41 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including COPD, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), encephalopathy (a group of conditions that cause brain dysfunction), and major depressive disorder.During a review of Resident 41's H&P, dated 7/17/2025, the H&P indicated, Resident 41 had fluctuating capacity to understand and make decisions.During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41 needed nursing staff supervision or touching assistance with showering and personal hygiene. The MDS indicated Resident 41 was independent with eating, oral hygiene, toileting, dressing, and putting on and taking off footwear.4. During a review of Resident 58's Face Sheet, the Face Sheet indicated, Resident 58 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] diagnoses of but not limited to major depressive disorder, anxiety, diabetes mellitus and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of resident 58's H&P dated 5/22/2025, the H&P indicated Resident 58 had the capacity to understand and make decisions. During a review of Resident 58's MDS dated [DATE], MDS indicated Resident 58 needed nursing staff supervision or touching assistance with toileting, showering, putting on and taking off footwear, personal hygiene, transferring, and walking 150 feet. 5. During a review of Resident 59's Face Sheet, the Face Sheet indicated, Resident 59 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] diagnoses including schizophrenia, anxiety, major depressive disorder and insomnia (trouble falling asleep or staying asleep).During a review of resident 59's H&P dated 7/18/2025, the H&P indicated Resident 59 had fluctuating capacity to understand and make decisions. During a review of Resident 59's MDS dated [DATE], MDS indicated Resident 59 needed nursing staff supervision or touching assistance with showering, lower body dressing, personal hygiene, and transferring.6. During a review of Resident 96's Face Sheet, the Face Sheet indicated, Resident 96 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] diagnoses of but not limited to COPD, hyperlipidemia (high cholesterol, abnormally high lipids in the blood), paranoid schizophrenia, and bipolar.During a review of resident 96's H&P dated 1/30/2024, the H&P indicated Resident 96 was able to make decisions for activities of daily living During a review of Resident

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' advance directive forms (a legal document indicating resident preference on end-of-life treatment decisions) were executed by the resident or the resident's legally authorized representative (is someone authorized to act on behalf of another person in legal matters), and medical records were updated to show documentation that advance directives were discussed and written information was provided to the residents and/or responsible parties for six of 10 residents (Resident 11, 12, 15, 22, 30, and 36).The facility failed to:1. Ensure facility's social worker did not sign residents' advance directive forms on behalf of the residents, even though documentation indicated each resident had a low Brief Interview for Mental Status ([BIMS]-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score and inability to provide informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered).These deficient practices violated the residents' and/or the representatives' right to be fully informed of the option to formulate an advance directive and had the potential to cause conflict with the residents' wishes regarding health care. Findings: A. During a review of Resident 30’s admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and paranoid schizophrenia (a mental health condition where a person experiences intense and persistent distrust and suspicious of others, often without good reason). During a review of Resident 30’s MDS dated [DATE] indicated Resident 30 had severe cognitive impairment. During a review of Resident 30’s History and Physical (H&P) dated 2/10/2025, the H&P indicated Resident 30 does not have the capacity to understand and make decisions. During a review of Resident 30’s Advance Directive Acknowledgement Form dated 8/16/2022, the Advance Directive Acknowledgment Form indicated there was no signature by Resident 30. During a review of Resident 36’s admission Record, the admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia, epilepsy (seizures- a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 36’s MDS dated [DATE], the MDS indicated Resident 36 had severe cognitive impairment. During a review of Resident 36’s Advance Directive Acknowledgement Form dated 1/24/2023, the Advance Directive Acknowledgment Form indicated there was no signature by Resident 36. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 8/14/2025 at 7:44 a.m., with Social Services Director (SSD) 1, SSD 1 validated both Resident 30 and 36’s Advance Directive’s were not accurately completed and neither resident had the capacity to make a decision regarding formulating an advance directive. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated it is important to ensure the residents’ advance directives were accurately completed so they were aware of the residents’ wishes regarding their care. The DON stated it was not right to have a resident sign a form when they are cognitively impaired. During a review of the facility’s policy and procedure (P&P) titled, “Advance Directives,” undated, the P&P indicated, “Prior to or upon admission of a resident to our facility, the Social Services Director of designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive.” During a review of the Social Services Director Job Description, undated, the Social Services Director Job Description indicated, “The Social Services Director will oversee the process of Advance Care Planning for each resident upon admission, and make sure any Advance Directives are reviewed with the resident/resident representative on a regular basis. The Director will ensure that staff members are made aware of the resident’s code status and end-of-life wishes and will assist with informing and educating residents and their representatives about health care options and ramifications.” B. During a review of Resident 11’s admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified dementia and unspecified mood affective disorder (mental illness that causes persistent and intense changes in person’s mood, energy, and behavior). During a review of Resident 11’s MDS dated [DATE], the MDS indicated Resident 11 had severe cognitive impairment. During a review of Resident 11’s MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills and required partial/moderate assistance (helper does less than half the effort) with bathing, dressing and personal hygiene. During a review of Resident 11’s History and Physical(H&P) dated 3/14/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions because resident’s judgement was impaired. During a review of Resident 11’s Care Plan titled, “Altered Thought Process,” initiated on 1/20/2025 and revised on 1/22/2025, The Care Plan indicated Resident 11 had periods of confusion, impaired cognitive skills, and disorientation, forgetfulness. The Care Plan’s goals indicated Resident 11 will communicate needs without frustration and accept staff support for ninety days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 11’s Acknowledgement of Receipt for Advance Directive /Medical Treatment Decisions, the Acknowledgement of Receipt for Advance Directive indicated Resident 11 refused to sign but resident’s name was written under the section stating resident and a staff witnessed the form. The form indicated Resident 11 did not choose to formulate or issue any advance directive at that time. During a concurrent interview and record review on 8/12/2025 at 2:49 p.m., with Social Worker (SW 2), Resident 11’s Acknowledgement of Receipt for Advance Directive was reviewed. SW 2 stated the reason why Resident 11 advance directive was documented as resident refuse because Resident 11’s family did not want to be involved in the decision making about resident’s advance directive. SW 2 stated the facility did not reoffer the advance directive after admission and agreed the Acknowledgement of Advance Directive was not acceptable because the resident was incapable of deciding for himself and not mentally competent(person has the ability to think clearly, understand information and make sound decisions for themselves). C. During a review of Resident 22’s admission Record, the admission Record indicated Resident 22 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified dementia(a progressive state of decline in mental abilities),unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and unspecified mood affective disorder(mental health condition characterized by symptoms of a mood disorder that do not fully meet the criteria for a specific named diagnosis). During a review of Resident 22’s MDS dated [DATE], the MDS indicated Resident 22 had severely impaired cognitive skills and required supervision or touching assistance (helper provides verbal cues and contact guard assistance as resident completes the activity) with eating, oral hygiene, dressing and toileting hygiene. During a review of Resident 22’s History and Physical (H&P-comprehensive assessment of patient’s health, combining a detailed medical history with a physical examination) dated 1/17/2025, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 8/12/2025 at 2:50 p.m., with SW 2, Resident 22’s Acknowledgement Receipt for Advance Directive was reviewed. SW 2 stated Resident 22 signed the Acknowledgement of Receipt for Advance Directive on 11/4/2023 and a facility representative witnessed the form. SW 2 agreed Resident 22 will not be able to decide or make a medical decision BIMS was 3 (BIMS of 3 indicated poor cognition[thought process]). SW 2 stated the facility should have applied for public guardianship (a court ordered role where the county’s public guardian serves as a legal guardian or conservator for individuals unable to care for themselves or manage their finances due physical or mental disabilities) and he did not know why it was not done. SW 2 stated Advance Directive is important so the resident will get a surrogate decision maker for his health and end of life care. During an interview on 8/13/2025, at 3:30 p.m. with DON, DON stated the licensed nurses should be involved and included in offering and educating residents about advance directives. DON believed the advance directive should be reoffered to residents after admission. DON stated advance directive is important because in the event when a resident cannot speak or decide in regards with end-of-life care, the advance will serve as guide on how to take care of them. (continued on next page)

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	08/14/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. During a review of Resident 12’s admission Record, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and heart failure (heart muscle is unable to pump enough blood to meet the body’s needs for blood and oxygen). During a review of Resident 12’s History and Physical (H& P) dated 2/10/2025, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12’s Minimum Data Set ([MDS]– a resident assessment tool) dated 6/8/2025, indicated Resident 12 had a BIMS score of 6, indicating severe cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 15’s admission Record, the admission Record indicated Resident 15 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and cardiomyopathy (a disease of the heart muscle that makes it harder to pump blood throughout the body). During a review of Resident 15’s History and Physical (H& P) dated 2/10/2025, the H&P indicated Resident 15 did not have the capacity to understand and make decisions. During a review of Resident 15’s MDS dated [DATE], the MDS indicated Resident 15 had a BIMS score of 3, indicating severe cognitive impairment. During a review of Resident 15’s Advance Directive/Medical Treatment Decisions, dated 3/19/2018, the Advance Directive/Medical Treatment Decisions indicated, the form was signed by the facility’s social worker rather than the resident or the resident’s legally authorized representative. During a concurrent interview and record review on 8/13/2025 at 11:34 a.m. with the Director of Nursing (DON), Resident 12’s Brief Interview for Mental Status (BIMS), dated June 2025 was reviewed. Resident 12’s BIMS score indicated a score of 3, indicating severe cognitive impairment. Further review of Resident 12’s Advance Directive, dated 3/27/2018, showed that the form was signed by the facility’s social worker rather than the resident or the resident’s legally authorized representative. The DON stated the social worker should not have signed the Advance Directive for Resident 12. The DON stated if residents cannot make decisions due to their cognitive status their legal representative or family member should be involved. The DON acknowledged that the process had not been followed appropriately and confirmed that the advance directive should not have been signed by facility staff. The DON stated the social worker should have contacted the responsible party or legal representative to ensure the residents’ wishes were properly documented. The DON stated the advance directive signed by the social worker may not be legally valid, which could lead to confusion during a medical emergency. The DON stated residents may not have their personal wishes honored, and their right to self-determination could be compromised. The DON stated inaccurate or unauthorized advance directives may result in treatment that was inconsistent with the resident’s values, such as unwanted resuscitation or the denial of care they would have chosen. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility’s policy and procedures (P&P) titled, “Advance Directive Staff Training Policy,” [undated], the P&P indicated, To ensure that all staff understand the facility’s process for discussing, honoring, and documenting resident advance directives in accordance with state and federal requirements, and to promote respect for resident rights and treatment preferences. During a review of the facility’s job description for the Social Service Director [undated] indicates, The Social Service Director will oversee the process of Advance Care Planning for each resident upon admission, and make sure that any Advance Directives are reviewed with the resident/resident representative on a regular basis. The Director will ensure that staff members are made aware of the resident’s code status and end-of-life wishes and will assist with informing and education residents and their representatives about health care options and ramifications.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 182) was appropriately notified regarding the changes in their Medicare coverage through provision of Notice of Medicare Non-Coverage (NOMNC) (a form that healthcare providers must give to Medicare beneficiaries to inform them that Medicare is expected to stop covering a specific service or item) form. This deficient practice had the potential to result in the responsible parties not being able to exercise their right to file an appeal.Findings:During a review of Resident 182's admission Record, the admission Record indicated Resident 182 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 182's Minimum Data Set (MDS- a resident assessment tool) dated 4/16/2025, the MDS indicated Resident 182's cognition (ability to think, understand, learn, and remember) was severely impaired. During a review of Resident 182's Social Services History and Initial assessment dated [DATE], the Social Services History and Initial Assessment indicated Resident 182 rarely/never understands, confused, and has a deficit in receptive communication (the ability to understand and process information received from others) . During a concurrent interview and record review on 8/14/2025 at 7:44 a.m., with the Social Services Director (SSD) 1, SSD 1 stated the NOMNC form indicted Resident 182 received a copy of the form and they held 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) meeting to discuss the Medicare coverage for Resident 182 being he not capable of understanding. SSD 1 stated they discussed applying for a guardianship (a court-ordered process where a person or entity is appointed to make personal decisions for another who is unable to make those decisions themselves) for Resident 182 which should have been done at the time of Resident 182's admission to the facility. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated she was not familiar with the NOMNC process but Resident 182 was mentally incapable of making decisions on his own and a guardian should have been appointed to make decisions on his behalf. The DON stated it was the residents right to understand what they are signing, and this did not occur for Resident 182. During a review of the facility's policy and procedure (P&P) titled, Advance Beneficiary Notices, undated, the P&P indicated, A NOMNC shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the required documentation for a transfer/discharge and assist resident with discharge planning for two of three sampled residents (Resident 51 and Resident 9) by failing to:1.Ensure a written copy of the bed hold notice was created and provided to Resident 51.2.Ensure the Notice of Proposed Transfer and Discharge was provided to the Ombudsman at the time of transfer to the General Acute Care Hospital (GACH) for Resident 51. This deficient practice resulted in the incomplete status of Resident 51's bed hold availability and had the potential to deny Resident 51's protection from being inappropriately discharged .3. Assist Resident 9 to look for placement back into the community.Findings: 1.During a review of Resident 51’s admission Record, the admission Record indicated Resident 51 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 51’s Minimum Data Set (MDS- a resident assessment tool) dated 5/16/2025, the MDS indicated Resident 51’s cognition (ability to think, understand, learn, and remember) was intact. During an interview on 8/13/2025 at 2:44 p.m., with the Administrator (ADM), the ADM provided a copy of the bed hold for Resident 51 signed upon admission of Resident 51 to the facility on 5/28/2025. The ADM stated the Social Services Director (SSD) used the bed hold Resident 51 signed on 5/28/2025 for her transfer to the GACH on 7/1/2025 and then had Resident 51 sign another bed hold upon her return from the GACH on 7/4/2025. During an interview on 8/13/2025 at 2:49 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the bed hold form should be completed at the time of a transfer so the residents were aware their bed will be held for them for seven days. During a concurrent interview and record review on 8/14/2025 at 7:44 a.m., with the Social Services Director (SSD) 1, SSD 1 validated the bed hold was not completed until Resident 51 returned to the facility from GACH and the Notice of Proposed Transfer and Discharge was faxed to the Ombudsman two days after Resident 51 transferred to GACH. SSD 1 stated the bed hold should be signed at the time of transfer so Resident 51 would know her bed would be held for seven days at the facility. SSD 1 stated the Notice of Proposed Transfer and Discharge should have been faxed to the Ombudsman at the time of discharge because they are the advocate for the residents and need to know when and why the resident was no longer at the facility. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated the bed hold should be signed by the resident on the day of transfer to GACH not when they return to the facility, so they were aware their bed will be held for seven days. The DON stated the Notice of Proposed Transfer and Discharge should be faxed to the Ombudsman upon the residents' time of transfer to ensure they were aware and to ensure its an appropriate and safe transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedure (P&P) titled, “Bed Hold Prior to Transfer, ” (undated), the P&P indicated, “Prior to transferring a resident to the hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident and/or resident representative regarding bed hold.” During a review of the facility’s P&P titled, “Transfer and Discharge” undated, the P&P indicated, “Provide a notice of the resident’s bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. Social Services Director, or designee, shall provide notice of transfer toa representative of the State Long-Term Care Ombudsman. ” During a review of the facility’s P&P titled, “Completeness and Accuracy of Documentation Policy” undated, “To maintain high-quality, truthful, and timely records that support resident care, legal compliance, and continuity of services.” 3.During a review of Resident 9’s admission Record dated 4/30/2025 the admission Record indicated Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anxiety (emotion characterized by feelings of tension, worried thoughts) bipolar disorder(a mental health condition that causes extreme mood swings that include emotional highs [mania] and lows[depression] that make it difficult to carry out day-to-day tasks and activities) and congenital (born with) deformity of the fingers and feet. During a review of Resident 9’s Minimum Data Set (MDS – a resident assessment tool) dated 7/16/2025, the MDS indicated Resident 9’s cognition was intact, the MDS also indicated Resident 9 needed set up or clean up assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 9’s Social Service Quarterly Note dated 7/16/2025, the Social Service Quarterly Note indicated discharge plan to be reviewed quarterly or as needed, or when Resident 9 and her Power of Attorney (POA- legal authorization for a designated person to make decisions about another medical care) decide to change Resident 9’s discharge plan, social services will assist with referrals, transitional needs and support. During an interview on 8/11/2025 at 12:47 p.m. with Resident 9, Resident 9 stated facility were not helping Resident 9 to find an assisted living (a system of housing and limited care that is designed for senior citizens who need some assistance with daily activities but do not require care in a nursing home) Resident 9 stated she informed the Social Services Director (SSD) a couple of weeks ago, that she need to be out of the facility and go to an assisted living. Resident 9 stated the SSD had not told her anything regarding her request two weeks that she was ready to go to an assisted living. During an interview on 8/12/2025 at 11:38 a.m., with the SSD, the SSD stated it was her responsibility to find placement for the residents when they are safe for discharge and that Resident 9 was safe to be discharged back into the community. The SSD stated that Resident 9 told her she wanted to go to an assisted living about a month ago and that she had not started looking for Resident 9’s placement. The SSD stated she should assist Resident 9 in finding an assisted living as Resident 9 was unhappy at the facility. The SSD stated Resident 9 could feel neglected and disrespected as the facility have not assisted Resident 9 with her request. (continued on next page)

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	055952	A. Building B. Wing	08/14/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/25 at 3:38 p.m. with the Director of Nursing (DON), the DON stated she was made aware by the SSD that Resident 9 wanted to go to an assisted living. The DON stated she was not sure why the SSD did not start looking for Resident 9 an assisted living facility. The DON stated Resident 9 was medically stable and could be discharged back into the community where she would have more choices and a better quality of life. During a review of the facility’s policy & Procedure (P&P) titled “Transfer and Discharge” (undated). the P&P indicated “This facility complies with federal regulations to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless…The transfer or discharge is appropriate because the residents’ health has improved sufficiently so the residents no longer need the service provided by the facility.”

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of two sampled residents (Resident 36 and 182) had:1.Implemented intervention of padded siderails for Resident 36 who had a seizure disorder 2.Developed a care plan for Resident 182 who had a sacrococcyx (tailbone) wound.These failures had the potential to not having appropriate interventions and for injury to the residents. Findings: 1.During a review of Resident 36’s admission Record, the admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (mental health condition), epilepsy (seizures- a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 36’s Minimum Data Set (MDS-resident assessment tool) dated 1/30/2023, the MDS indicated Resident 36 had severe cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 36’s care plan titled “Resident 36 at risk for injury and falls related to seizure disorder revised 9/25/2024, the care plan goals indicated Resident 36 will not have a seizure related injury with interventions including padded side rails in bed. During an observation on 8/11/2025 at 10:45 a.m., in Resident 36’s room, no padded side rails were observed on Resident 36’s bed. During a concurrent observation and interview on 8/13/2025 at 11:54 a.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated there were no padded side rails for Resident 36. CNA 3 Resident 36 should have padded siderails to protect Resident 36 from getting injured if she were to have a seizure. During a concurrent interview and record review on 8/13/2025 at 2:49 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 36 had a care plan for seizures with interventions including padding the side rails. LVN 1 stated Resident 36’s side rails were not padded, which means they are not following the care plan. LVN 1 stated there should be padding on her side rails to prevent her from getting injured if she were to have a seizure. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated the staff should be following the care plan for Resident 36’s seizure precautions by having her side rails padded. The DON stated following the seizure care plan by padding the side rails was important for Resident 36’s safety and injury prevention. During a review of the facility policy and procedure (P&P) titled, “Comprehensive Care Plans, undated, the P&P indicated, “Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.” (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 182’s admission Record, the admission Record indicated the facility admitted the resident on 4/9/2025 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus type II (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 182’s Minimum Data Set (MDS- resident screening tool) dated 4/26/2025 indicated the resident has severely impaired cognition (ability to think and understand) and required substantial/maximal assistance from staff for rolling left to right, sit to stand and transfers. During a review of Resident 182’s Medication Administration Record (MAR) from 7/29/2025 through 8/9/2025, indicated Resident 182 was to receive petrolatum-zinc oxide topical (on the skin), Medihoney (honey topical dressing) covered with a four by four (4x4) dry dressing daily for wound care. During a review of a Wound Consult Note dated 7/12/2025 indicated Resident 182 had an open wound to the sacrococcyx area, with treatment recommendations of collagen powder. During an interview with Certified Nursing Assistant (CNA) 8 on 8/11/25 at 10:09 a.m., CNA 8 stated Resident 182 does not respond to questions. CNA 8 stated Resident 182 required repositioning every 2 hours. During an interview and concurrent record review on 8/13/2025 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 5, there was no care plan found for a new wound to the saccrococyx dated 7/12/2025. LVN 5 stated a care plan should have been written for skin impairment related to an open wound and interventions to include using an APP (Alternating Pressure- a medical device with air-filled cells that cycle between inflating and deflating to redistribute a person's body weight, preventing and treating pressure ulcers (bedsores) by avoiding prolonged pressure on any single area of the skin) mattress and wound care per physician’s order. LVN 5 stated, “I forgot to write it because I was still training with the DON (Director of Nursing)”. During a concurrent interview and record with the Director of Nursing (DON) on 8/13/2025 at 1:00 p.m., the DON stated the care plan provides guidance to nurses and staff on how to care for a resident. The DON stated if there was no care plan the resident could end up with sepsis or be harmed. During a review of the facility’s policy and procedure (P&P) titled ‘” Comprehensive Care Plans”, undated, the P&P indicated “It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 148) did not receive medication without physician's order.This failure resulted in a medication error and had the potential to place Resident 148 for an adverse reaction(an undesirable or harmful effect from a drug or treatment).Findings:During a review of Resident 148's admission Records, the admission Records indicated Resident 148 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-- group of lung disease that block the airflow which can cause difficulty of breathing), epilepsy(sudden burst of electrical activity in the brain causing change in behavior, movements, feelings and levels of consciousness), hypothyroidism (condition where the thyroid does not produce enough thyroid hormones to meet the body's needs), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 148's Minimum Data Set (MDS- a resident assessment tool) dated 6/11/2025, the MDS indicated Resident 148 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills and required setup or clean-up assistance (helper sets up or cleans up as resident completes the activity) with eating, oral hygiene, transfer and bed mobility.During a medication pass observation on 8/13/2025, at 8:39 a.m. with Licensed Vocational Nurse (LVN 4), LVN 4 poured Geritussin (medicine that can treat cough) syrup in a medicine cup and administered it to Resident 148.During a concurrent interview and record review on 8/13/2025, at 2:43 p.m., with LVN 4, Resident 148's Order Summary Report was reviewed. LVN 4 stated that through record review there was no physician order for Geritussin. LVN 4 stated she administered 5 milliliters (ml- unit of measurement) of Geritussin to Resident 148 because of his cough. LVN 4 stated Geritussin was an over-the-counter medicine (drugs that can be bought directly from a pharmacy or store without a prescription) that was why she administered it to Resident 148. LVN 4 stated she was not sure if there was a facility's policy in the administration of over-the-counter medication to residents without a physician order. LVN 4 stated she should have called or notified the physician about Resident 148's cough and obtained a physician order to administer Geritussin.During an interview on 8/13/2025, at 3:04 p.m. with the Director of Nursing (DON), the DON stated it was not the facility's practice and standard of care to administer over the counter medication without the physician's order. The DON stated LVN 4 should have told Resident 148 that there was no order for Geritussin and should have called or notified the physician about Resident 148's cough. The DON stated the resident could develop allergic reactions to the medicine or cause interaction with Resident 148's other medicines. The DON stated Geritussin could cause reaction that could lead complications including death.During a review of facility's policy and procedure (P&P) titled, Medication Administration, revised 11/2017, the P&P indicated Medicines are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice.

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	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure two of three sampled residents (Resident 125 and Resident 3) who were dependent on activities of daily living (ADLS- activities such as bathing, dressing, and toileting a person performs daily) received the necessary care and services to maintain good grooming and personal hygiene by failing to:1.Ensure Resident 125 was provided with oral care. 2.Ensure Resident 3's long and dirty fingernails were trimmed. These failures had the potential to result in Resident 125 and Resident 3 feeling neglected and not thoroughly groomed which could lead to skin breakdown, infection and teeth/gum issues.Findings: 1.During a review of Resident 125’s admission Record, the admission Record indicated Resident 125 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (lack of adequate blood supply to the brain), dementia (a progressive state of decline in mental abilities), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 125’s Minimum Data Set (MDS- a resident assessment tool) dated 7/31/2025, the MDS indicated Resident 125’s cognition (ability to think, understand, learn, and remember) was severely impaired and was dependent (helper does all the effort) with Activities of Daily Living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a concurrent observation and interview on 8/11/2025 at 10:33 a.m., with Licensed Vocational Nurse (LVN) 1 in Resident 125’s room, Resident 125 was observed lying in bed with dry lips and a crusty yellowish film around Resident 125’s mouth. LVN 1 stated it was important to provide good oral care to the residents because poor oral hygiene could lead to oral problems. LVN 1 stated not receiving good oral care could cause Resident 125 to feel she was not being cared for. During an interview on 8/14/2025 at 12:48 p.m. with the Director of Nursing (DON), the DON stated oral care should be done every shift and as needed for residents who were unable to do on their own, especially residents receiving gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GT) feedings. The DON stated oral care was important to prevent dry mouth and “it was just nasty” which could affect the resident’s self-esteem. During a review of the facility’s policy and procedure (P&P) titled, “Activities of Daily Living (ADLs), undated, the P&P indicated, “A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.” During a review of the facility’s P&P titled, “Oral Care” undated, the P&P indicated, “It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral disease.” (continued on next page)

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	055952	A. Building B. Wing	08/14/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.During a review of Resident 3’s admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebrovascular disease (damage to the brain from interruption of its blood supply), hemiplegia on right dominant side (paralysis of the right side of the body), schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior), absence of right leg above knee, and major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 3’s MDS dated [DATE], the MDS indicated Resident 3 had severely impaired cognitive skills and required partial/moderate assistance(helper does less than half the effort) with bathing, personal hygiene, toileting hygiene and lower body dressing (dress and undress below the waist). During a review of Resident 3’s Care Plan titled “Resident needs assistance with personal hygiene, bed mobility, walking, toilet use, and bathing initiated on 11/1/2024, the Care Plan indicated interventions including providing ADL care as needed and cue the resident with ADL care needs. During an observation on 8/12/2025, at 9:55 a.m. in the facility’s hallway, Resident 3’s fingernails on the right hand were long and left hand had long and dirty fingernails. During a subsequent observation on 8/13/2025, at 12:19 p.m. in Resident 3’s room, Resident 3 was using left hand with dirty and long fingernails to pick up food during lunch. During a concurrent observation and interview on 8/14/2025, at 9:45 a.m. with Certified Nursing Assistant (CNA 5) in Resident 3’s room, CNA 5 stated the staff will check resident’s fingernails during shower and will notify the charge nurse if a resident requires trimming of their fingernails. CNA 5 agreed Resident 3’s fingernails were long and dirty and should be trimmed. CNA 5 stated Resident 3 always used his left hand and could get sick because long and dirty fingernails carry bacteria. During an interview on 8/14/2025, at 10:34 a.m. with LVN 7, LVN 7 stated she was not aware Resident 3’s fingernails were long and dirty. LVN 7 stated the CNAs will notify the charge nurse if a resident needs fingernails trimming because they must be present when the CNA trims residents’ fingernails to prevent injury. LVN 7 agreed Resident 3’s fingernails were overgrown and dirty and should be trimmed because the resident could get infection. During an interview on 8/14/2025, at 11:16 a.m. with the DON, the DON stated Resident 3 could get an infection from his long and dirty fingernails because long fingernails could dig into the skin causing discomfort and infection. During a review of facility’s P&P titled, “Activities of Daily Living (ADLs),” undated, the P&P indicated “The facility will provide the necessary services to maintain grooming, personal and oral hygiene on residents who are unable to carry out activities of daily living.”

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	055952	A. Building B. Wing	08/14/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing 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 one sampled residents (Resident 152) 152 was provided with reading glasses when his eyeglasses broke.This failure had the potential to negatively affect Resident 152's quality of care and his safety at risk.Findings: During a review of Resident 152's admission Record, the admission Record indicated Resident 152 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot filter blood effectively) and anxiety (emotion characterized by feelings of tension, worried thoughts).During a review of Resident 152's History & Physical (H&P) dated 8/01/2025, the H&P indicated Resident 152 was a poor historian with cognitive (ability to think, understand, learn, and remember) impairment. During a review of Resident 152's Minimum Data Set (MDS - a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 152 had severe cognitive impairment. The MDS also indicated Resident 152 needed substantial/maximal assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 152 had impaired vision sees large print, but not regular print in newspaper/books.During a review of Resident 152's Eye Consultation dated 7/3/2025, the Eye Consultation indicated Resident 152 needed reading glasses.During a concurrent observation and interview on 8/11/2025 at 10:19 a.m. with Resident 152 in the hallway, Resident 152 was very agitated and stated he need new eyeglasses as his eyeglasses broke, Resident 152 was observed not wearing any eyeglasses.During an interview on 8/11/2025 at 11:01 a.m. with Certified Nursing Assistant 8 (CNA 8), CNA 8 stated she informed Social Services Director (SSD) two weeks ago that Resident 152 needed eyeglasses. CNA 8 stated the SSD told her she would work on it. CNA 8 stated residents can get hurt and become depressed if they cannot see well.During an interview on 8/11/2025 at 11:31 a.m. with the SSD, the SSD stated she was made aware that Resident 152 needed glasses about a week ago and that she had not done anything about it. The SSD stated not being able to see could take a toll on Resident 152's mental health and that there was potential for harm to Resident 152 when not wearing his eyeglasses.During an interview on 8/14/2025 at 12:52 p.m. with the Director of Nurses (DON), the DON stated the SSD should have called the optometrist (eye care specialist) when she was informed Resident 152 needed eyeglasses. The DON stated residents will become more agitated, frustrated and could even get hurt when not wearing their eyeglasses.During a review of the facility's policy and procedure (P&P) titled Hearing and Vision Services (undated), the P&P indicated It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker designee is responsible for assisting residents and their families in locating and utilizing any available resources for the provision of the vision and hearing and assistive devices to maintain vision include but are not limited to, glasses, contact lenses and magnifying glasses or other devices that are used by the resident.

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	055952	A. Building B. Wing	08/14/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure oxygen tubing start date or change date was labeled for one of one resident (Resident 182) who required intermittent oxygen.This failure had the potential for respiratory infections. Findings: During a review of Resident 182's admission Record, the admission Record indicated the facility admitted the resident on 4/9/2025 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus type II (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 182's Minimum Data Set (MDS- resident screening tool) dated 4/26/2025 indicated the resident has severely impaired cognition (ability to think and understand) and required substantial/maximal assistance from staff for rolling left to right, sit to stand and transfers.During an observation on 8/11/2025 at 1:49 p.m. in Resident 182's room, the resident's oxygen tubing did not have a label for start date or change date. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 6 on 8/14/2025 at 11:27 a.m., in Resident 182's room, LVN 6 stated the oxygen tubing was changed every week. LVN 6 stated there was no date changed label on Resident 182's oxygen tubing. LVN 6 stated if the oxygen tubing was not changed, it could become an infection control issue. During a review of the facility's policy and procedure (P&P) titled Oxygen Labeling, undated, indicated 1) Routine Tubing change: Oxygen tubing will be changed once per week when the oxygen bag is replaced.After tubing is changed, the oxygen bag will be labeled to indicate the date of the tubing change.Staff will ensure that the new tubing is properly connected and functioning correctly after each change.

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	055952	A. Building B. Wing	08/14/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interviews and record review the facility failed to ensure staff were competent with facility policies and procedures by failing to:A. Ensure two of two licensed staff (Registered Nurse Supervisor 1 and Licensed Vocational Nurse 3) were able to verbalize the process for securing emergency medication kits (E-kits).B. Ensure annual performance evaluations (supervisor looks at how well staff are doing their job and gives feedback) were documented and completed for five of five facility staff as required by the facility policy and regulatory standards.This deficient practice had the potential to result in staff competency concerns going unrecognized, unmet training needs, and potential to result in delays during medical emergencies, unauthorized access, and loss of critical medications. Findings: A. During a concurrent observation and interview on 8/14/2025 at 10:07 a.m. with Registered Nurse Supervisor (RNS) 1 for intramuscular Emergency Kit (E-Kit) in Medication Storage 1 in building A, RNS 1 stated the E-Kit replacement process was to log the medications taken out on the paper enclosed in the E-Kit, then call the pharmacy to replace the E-Kit. RNS 1 was unable to explain the process of securing the E-Kit after opening. RNS 1 stated she had not received an in-service for E-Kit. During a concurrent observation and interview on 8/12/2025 at 10:42 a.m. with Licensed Vocational Nurse (LVN) 3 for intramuscular E-Kit in building B, LVN 3 stated when the locks are red, the E-Kit had not been opened. LVN 3 stated to secure the E-Kit after opening, place the E-kit back in the original plastic bag, make a note, then place the E-Kit back in the storage room. During an interview on 8/14/2025 at 12:24 p.m. with the Director of Nursing (DON), the DON stated if the E-Kits are not properly locked and placed in a secure storage area, the E-kits would potentially be accessed by anyone for their own use. During a review of the facility’s Policy and Procedure (P&P) titled “Emergency Pharmacy Service and Emergency Kits (E-Kits) dated 01/2024 indicated “One copy of this information should be immediately faxed to the pharmacy or placed within the resealed emergency kit until it is scheduled for exchange…Before reporting off duty, the charge nurse indicates the “opened” or “sealed” status of the emergency kit at the shift change report and transfers the new medication orders to oncoming staff.” B. During a concurrent interview and record review on 8/14/2025 at 10:12 a.m. with the Director of Staff Development (DSD), the DSD acknowledged that five employees did not receive their required annual performance evaluations. The DSD stated the annual performance evaluations for the staff were not done due to the current workload. The DSD acknowledged that this does not meet facility or regulatory expectations. The DSD stated the facility tries to monitor staff performance through direct observation, competency checks, and ongoing in-service training. The DSD stated she acknowledges that without annual evaluations, some competency gaps may not be fully documented. The DSD stated that without annual performance evaluations, staff competency issues may go unrecognized, which could affect the quality and safety of care provided to the residents. (continued on next page)

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	055952	A. Building B. Wing	08/14/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/14/2025 at 2:25 p.m. with the Director of Nursing (DON), the DON stated the facility has a process in place for annual performance evaluations for all staff. The DON stated missing these evaluations could potentially affect residents because staff competencies and areas needing improvement were not formally assessed, which may impact the quality and consistency of care. The DON stated the facility will be taking corrective action to ensure all evaluations are completed on schedule moving forward. The DON stated to ensure better oversight of staff development and maintain compliance with training requirements; she has planned to hire an additional DSD. During a review of the facility’s policies and procedures (P&P) titled, “Evaluation Process, ” [undated], the P&P indicated, “It is the policy of our facility to review the work performance of employees with a formal written evaluation yearly. At the time the evaluation is given, the facility may or may not make salary/wage adjustments. The P&P indicated there is no guarantee that a salary/wage rate increase will be given automatically each year. The P&P indicated factors that will be considered in making decisions about salary/wage adjustments include, but are not limited to job performance, achieving preset goals, attendance record, adherence to workplace policies, etc.” During a review of the Director of Staff Development (DSD) job description, the job description indicated the following responsibility: the DSD participates in the completion of the facility assessment at least annually to determine the knowledge and skill required among staff to meet residents’ needs.

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	055952	A. Building B. Wing	08/14/2025

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure facility staff provided care to residents with Post-Traumatic Stress Disorder (PTSD- a mental health condition that can develop after experiencing or witnessing a traumatic event) for two of two sampled residents (Resident 168 and 17). The facility failed to:1. Ensure Resident 168 and 17 were assessed, monitored, and provided interventions to help with Resident 168 and Resident 17 triggers. 2.Ensure facility staff who provided care to residents were aware of Resident 168 and Resident 17's diagnoses of PTSD and what triggers to monitor for. 3.Social Services Director (SSD) 1 failed to demonstrate competency on how to assess, document, and identify PTSD and triggers upon admission to the facility. These deficient practices resulted in a lack of interventions to address Resident 168 and Resident 17 PTSD triggers Findings: 1.During a review of Resident 168’s admission Record, the admission Record indicated Resident 168 was admitted to the facility on [DATE] with diagnoses including PTSD, major depressive disorder (a mood disorder that causes a persistent feeling and loss of interest), and anxiety (a common mental health condition characterized by excessive worry, fear, and unease). During a review of Resident 168’s Minimum Data Set (MDS- a resident assessment tool) dated 7/16/2025, the MDS indicated Resident 169’s cognition (ability to think, understand, learn, and remember) was intact. During a review of Resident 168’s Social Service History and Initial assessment dated [DATE], the Social Service History and Initial assessment indicated there was no assessment completed for PTSD. During an interview on 8/12/2025 at 2:20 p.m., with SSD 1, SSD 1 stated she was unaware of assessments for residents with PTSD or their triggers. During a concurrent interview and record review on 8/12/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON was unable to locate documentation for residents with PTSD and their triggers. The DON stated it was important to screen residents for PTSD to know what their triggers were and prevent re-traumatizing the residents. The DON stated Resident 168 has a diagnosis of PTSD and this should have been assessed upon admission to the facility but was not done. During an interview on 8/12/2025 at 3:03 p.m., with Resident 168, Resident 168 stated no one at the facility has spoken to him regarding his PTSD or triggers. Resident 1 stated it would be helpful if the staff were aware of his triggers because not knowing them causes him to feel uncomfortable. Resident 168 stated some of his triggers are loud noises and being around large groups of people which causes him to have a panic attack (a brief episode of intense anxiety, which causes the physical sensations of fear) and withdraw. During an interview on 8/13/2025 at 9:26 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was unaware Resident 168 had PTSD or what his triggers were. (continued on next page)

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	055952	A. Building B. Wing	08/14/2025

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/2025 at 9:55 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did not know Resident 168 had PTSD and was not aware of his triggers but should know these things. LVN 1 stated its important to know Resident 168 has PTSD and what his triggers were, so she knows what to assess for and how to prevent Resident 168 triggers. During an interview on 8/13/2025 at 7:44 a.m., with SSD 1, SSD 1 stated she did not assess Resident 168 for PTSD or his triggers and should have for his mental well-being. During a review of the facility’s Social Services Director Job Description, undated, the Social Services Director Job Description indicated, “The Social Services Director will complete and/or direct/delegate the completion of the social services component of the comprehensive assessment. The Social Services Director will also contribute to and/or direct/delegate contribution of social services goals and approaches to the comprehensive care plan. These goals and interventions will be individualized to match the skills, abilities, and interests/preferences of each resident in compliance with Federal and State regulations, to include identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident. The Social Services Director will coordinate implementation and oversight of procedures to ensure social services actions and interactions are adequately documented in each resident’s medical record, and that legal, ethical, and professional standards of social work practice and being upheld in written recordings.” 2. During a review of Resident 17’s admission Record dated 4/25/2025, the admission Record indicated Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including chronic kidney disease (a long-term condition where the kidneys are damaged and cannot filter blood effectively), PTSD and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 17’s History & Physical (H&P) dated 7/22/2025, the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions. During a review of Resident 17’s MDS dated [DATE], the MDS indicated Resident 17 cognition was intact, the MDS indicated Resident 17 needed set up or clean up assistance with Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 17 had a psychiatric (mental)/mood disorder, and PTSD. During a review of Resident 17’s Care Plan titled “Resident at risk for danger to self and others” dated 11/29/2024 revised on 12/09/2024, the care plan indicated Resident 17 had behaviors of agitation (a state of extreme restlessness, tension, and irritability) and angry outbursts related to his PTSD. The care plan interventions indicated to determine triggers and des-escalation (reducing the intensity of a conflict or potentially violent situation) techniques and to educate staff. During a concurrent observation and interview on 8/11/2025 at 2:11 p.m., Resident 17 was observed walking around his bed talking to himself. Resident 17 stated I cannot talk right now. During a concurrent observation and interview on 8/14/2025 at 1:54 p.m., Resident 17 was observed leaning against a wall near his room talking to himself. Resident 17 stated I cannot talk right now. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/2025 at 2:20 p.m., with SSD 1, SSD 1 stated she was unaware of assessments for residents with PTSD or their triggers. During a concurrent interview and record review on 8/12/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON was unable to locate documentation for residents with PTSD and their triggers. The DON stated it was important to screen residents for PTSD to know what their triggers are to help prevent re-traumatizing the residents. The DON stated Resident 17 does have a diagnosis of PTSD and this should have been assessed upon admission to the facility but was not done. During a review of the facility’s policy and Procedure (P&P) titled (Behavior Assessment and monitoring) the P&P indicated “As part of the initial assessment, the nursing staff and Attending Physician will identify individuals with a history of impaired cognition (e.g., dementia, mental retardation), problematic behavior. or mental illness (e.g., bipolar disorder or schizophrenia). The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition.”

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	08/14/2025

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Torrance Care Center West, Inc	4333 Torrance Blvd Torrance, CA 90503

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure one of three sampled residents (Resident 168) with Post-Traumatic Stress Disorder (PTSD- a mental health condition that can develop after experiencing or witnessing a traumatic event) was referred to a psychologist (a trained mental health professional who helps people learn healthy ways to handle mental health challenges) per Resident 168 request and physician order. This deficient practice resulted in Resident 168 not receiving the proper assessment, necessary treatment, and resources for his diagnosis of PTSD. Findings: During a review of Resident 168's admission Record, the admission Record indicated Resident 168 was admitted to the facility on [DATE] with diagnoses including PTSD, major depressive disorder (a mood disorder that causes a persistent feeling and loss of interest), and anxiety (a common mental health condition characterized by excessive worry, fear, and unease). During a review of Resident 168's Minimum Data Set (MDS- a resident assessment tool) dated 7/16/2025, the MDS indicated Resident 169's cognition (ability to think, understand, learn, and remember) was intact. During a review of Resident 168's Care Plan titled Resident 168 was at risk for disturbed thought processes, panic level of anxiety feelings of tension, worried thoughts), depressive symptoms (feeling of sadness and loss of interest), lability of mood (frequent, rapid, and sometimes intense shifts in emotions), and disturbance in sleep (disruptions to the normal sleep cycle) revised 7/11/2025, the Care Plan goals indicated for Resident 168 to openly discuss fears and use of effective coping behaviors to resume normal life and will exercise control over his intrusive (something unwanted, annoying, or unwelcome that interrupts your thought) thoughts by being calm and relaxed. The Care Plan interventions indicated for Resident 168 to receive medication as ordered, encourage verbalize feelings, psychology consultation (assessment of the patient's present state of mind and how it affects his or her behavior and function) as needed and avoid physical contact. During a review of Resident 168's Medication Review Report, the Medication Review Report indicated an order was placed on 7/9/2025 for Depakote (mood stabilizer medication that works in the brain) twice a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by impulsive and unpredictable behavior with no regards to safety. The Medication Review Report indicated an order was placed on 7/9/2025 for Lexapro (a medication to help improve mood) each morning for depression (a mood disorder that causes persistent feelings of sadness and loss of interest in activities such as sleeping and eating) manifested by verbalizing feeling depressed and wanting to overdose (takes more of a substance [like drugs or alcohol] than their body can handle), causing harmful or even deadly effects). During a review of the Order Summary Report, the Order Summary Report indicated an order was placed 7/9/2025 for a psychologist consult.During an interview on 8/12/2025 at 3:03 p.m., with Resident 168, Resident 168 stated he asked the Social Services Director (SSD) 1 to see a psychologist but she did not follow up with him.During an interview on 8/14/2025 at 7:44 a.m., with SSD 1, SSD 1 stated she recalls Resident 168 requesting to see a psychologist but assumed because there was a standing order for a psychologist consult, she did not know an appointment needed to be made for Resident 168. SSD 1 stated she did not document this conversation or follow up with Resident 168's request to see a psychologist but should have, especially since he has PTSD and it could improve his mental well-being. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated if a resident requests to see a psychologist, SSD 1 should make the appointment as well as document Resident 168's request. The DON stated SSD 1 not following through with Resident 168's request to see a psychologist, could cause Resident 168 to feel frustrated and potentially cause his condition to worsen. During a review of the facility's policy and procedure (P&P) titled, Social Services undated, the P&P indicated, The facility, regardless of size, will provide medically related social services to each resident, to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. The social worker, or social service designee, will pursue the provision of any identified need for medically related social services of the resident. Services to meet the resident's needs may include providing or arranging for needed mental and psychosocial counseling services.During a review of the facility's Social Services Director Job Description, undated, the Social Services Director Job Description indicated, The Social Services Director will coordinate implementation and oversight of procedures to ensure social services actions and interactions are adequately documented in each resident's medical record, and that legal, ethical, and professional standards of social work practice and being upheld in written recordings

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	08/14/2025

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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	055952	A. Building B. Wing	08/14/2025

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically related social services to meet residents' needs for two of four sampled residents (Resident 3 and Resident 97) needing dental services by failing to:1.Follow up Resident 3's dental recommendation for teeth extraction.2.Follow up Resident 97's dental recommendation for dentures.This failure had the potential to put Resident 3 and Resident 97 at risk for delayed treatment and care which could lead to weight loss. Findings:1.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebrovascular disease (damage to the brain from interruption of its blood supply), hemiplegia on right dominant side (paralysis of the right side of the body), schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior), absence of right leg above knee, and major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 3's Minimum Data Set (MDS-resident assessment tool) dated 8/1/2025, the MDS indicated Resident 3 had severely impaired cognitive (ability to think, understand, learn, and remember) skills and required partial/moderate assistance(helper does less than half the effort) with bathing, personal hygiene, toileting hygiene and lower body dressing (dress and undress below the waist).During a record review of Resident 3's Onsite Mobile Dental Note dated 3/12/2025, the Onsite Mobile Dental Note indicated the resident had mobile teeth (loosening of tooth within its socket) and the dentist recommended teeth extractions.During an observation on 8/12/2025, at 8:29 a.m., in the hallway, Resident 3 had missing teeth on the upper and lower mouth.During a concurrent interview and record review on 8/12/2025, at 2:24 p.m. with Social Service (SW2), Resident 3's Onsite Mobile Dental Note was reviewed. SW2 stated Resident 3 does not have any family members. SW 2 verified through record review Resident 3 was seen by a dentist on 3/12/2025 and the dentist recommended teeth extractions. SW 2 stated Resident 3 had not seen the dentist since 3/12/2025. SW 2 stated he should have followed up the dentist's recommendations about teeth extraction and made an appointment. SW 2 stated Resident 3 can be at risk for chewing difficulties and can cause discomfort to Resident 3. During an interview on 8/14/2025, at 11:16 a.m. with the Director of Nursing (DON), the DON stated Resident 3's missing teeth could affect Resident 3's ability to chew food leading to weight loss.During a review of facility's policy and procedure (P&P) titled, Social Services, (undated) , the P&P indicated The social worker will pursue the provision of any identified need for medically related social services of the resident in order to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.During a review of facility's P&P titled, Dental Services, (undated), the P&P indicated The facility will assist the resident with making dental appointments and arranging transportation.2. During a review of Resident 97's, admission Record, the admission Record indicated the facility initially admitted Resident 97 on 11/21/2023 and was readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that can affect thoughts, mood and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and depression (deep sadness or emptiness that does not go away). During a review of Resident 97's, Minimum Data Set (MDS-a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 97's cognition (thought process) was not impaired. During a review of Resident 97's Care Plan Report initiated on 12/03/2024, and revised on 5/26/2025, the Care Plan Report indicated Resident 97 was at risk for inadequate nutrition and at risk for alteration in comfort related to broken teeth and cavities. During an interview on 8/11/2025, at 2:00 p.m., with Resident 97, Resident 97 stated, he has difficulty chewing meat because of his missing teeth and stated he has informed the Social Worker several times that he needed dentures. During a review of Resident 97's, Onsite Mobile Dental record dated 12/23/2024, the record indicated, Resident 97 reported difficulty chewing due to lost teeth, and treatment recommendations indicated, partial upper and lower dentures (a set of removeable false teeth used to replace missing teeth while the person still has some of their natural teeth) were recommended. During a review of Resident 97's Onsite Mobile Dental record dated 8/01/2025, the record indicated the treatment plan recommendations were for dentures. During an interview on 8/12/2025 at 10:00 a.m., with the Social Services Director (SSD) 1, SSD 1 stated, Resident 97's dental service needs should have been followed up. The SSD stated there was no follow up by Social Services regarding Resident 97's dental needs since 8/15/2024. During an interview on 8/14/2025 12:15 p.m., with the Director of Nurses (DON), the DON

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	055952	A. Building B. Wing	08/14/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review , the facility failed to ensure Zyprexa (Olanzapine- medicine that treats mental disorders , including schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder[sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs])10 milligrams (mgs.- unit of measurement) were not in the same plastic bag mixed with Zyprexa 5 mgs. and labeled for Zyprexa 5 mgs outside the plastic container for one of four sampled residents (Resident 148).This failure had the potential to place Resident 148 at risk for medication error.Findings:During a review of Resident 148's admission Records, the admission Records indicated Resident 148 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified psychosis(a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and schizoaffective disorder, bipolar type(a mental illness that can affect thoughts, mood, and behavior with mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 148's Minimum Data Set (MDS- a resident assessment tool) dated 6/11/2025, the MDS indicated the resident had moderately impaired cognitive (ability to think, understand, learn, and remember) skills and required setup or clean-up assistance (helper sets up or cleans up as resident completes the activity) with eating, oral hygiene, transfer and bed mobility.During a review of Resident 148's Medication Administration Record (MAR), the MAR indicated Resident 148 was on Zyprexa 5 mgs. one tablet by mouth in the morning for schizoaffective disorder manifested by auditory hallucinations (hearing voices of people to get him, making him fearful). The MAR indicated Zyprexa 5 mgs. was ordered on 8/5/2025 and was administered to Resident 148 on 8/13/2025, at 9:00 a.m.During a review of Resident 148's MAR , the MAR indicated Zyprexa 10 mgs. one tablet by mouth in the evening for schizoaffective disorder manifested by auditory hallucinations and ordered on 8/4/2025. The MAR indicated Zyprexa 10 mgs., was scheduled to be administered to Resident 148 at 5:00 p.m.During a medication pass observation on 8/13/2025, at 8:39 a.m. with Licensed Vocational Nurse (LVN 4), LVN 4 removed the tablet of Zyprexa 5 mgs. from the plastic bag and into a medicine cup. LVN 4 administered Zyprexa 5 mgs. to Resident 148. Observed the Zyprexa 5 mgs. and Zyprexa 10 mgs were mixed in same plastic bag labeled as Zyprexa 5 mgs tablet give 1 tablet by mouth every morning.During an interview on 8/13/2025, at 2:43 p.m. with LVN 4, LVN 4 stated the licensed nurses were responsible in ensuring the correct medications and doses are stored in the plastic bag. LVN 4 stated she did not know who placed the Zyprexa 5 mgs. and 10 mgs in the same plastic bag. LVN 4 stated Zyprexa 10 mgs should be in another plastic bag intended for the evening dose. LVN 4 stated mixing Zyprexa 5 mgs. and Zyprexa 10 mgs in one plastic bag had the potential for medication error.During an interview and review on 8/13/2025, at 3:04 p.m. with Director of Nursing (DON), showed Resident 148's picture of Zyprexa ‘s plastic bag the DON. The DON stated Resident 148 can be at risk of having an overdose of Zyprexa and a possibility of a medication error because both medications with different doses were mixed in the same plastic bag. The DON stated the licensed nurses should have separated Zyprexa 10 mgs. from Zyprexa 5 mgs. then transfer the Zyprexa 10 mgs. in the medication cart for the evening dose. The DON stated it was plain carelessness, and this practice can place the lives of residents at stake.During a review of facility's policy and procedure (P&P) titled, Medication Storage, undated , the P&P indicated The facility will store medications according to the manufacturer's recommendations and will ensure sanitation, moisture control, segregation and security of stored medicines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure eight of eight residents (Resident 160, Resident 11, Resident 16, Resident 22, Resident 26, Resident 61, Resident 84, and Resident 92) opened medication bottles were labeled with the date opened.This failure had the potential to result in the use of medications beyond their recommended stability period, reducing their efficacy, and compromising resident safety through the administration of expired and contaminated medications. Findings:During a concurrent observation and interview on [DATE] at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, for morning (AM) medication cart located in building B, the following were inside the cart without opened dates:1. Valproic Acid (medication used to treat seizures, manic episodes associated with bipolar disorder, and to prevent migraine headaches) for Resident 11, 2. Constulose (used to treat chronic constipation) for Resident 61, 3. Constulose for Resident 84, 4. Megestrol (medication used to increase appetite and cause weight gain in patients experiencing unexplained, significant weight loss) and Valproic Acid for Resident 16, 5. Valproic Acid for Resident 160, 6. Constulose for Resident 26, 7. Enulose (used to treat constipation) for Resident 92, 8. Constulose for Resident 22 LVN 2 stated all medications should be labeled with the opened date. LVN 2 stated the potential outcome for not labeling medications with open dates would be the medications will not have the same effect on the residents.During an interview on [DATE] at 11:14 a.m. with Director of Nursing (DON), the DON stated open date labels were placed on the medication bottle upon opening, then returned in the medication cart. The DON stated potential outcomes for residents included decreased effectiveness of the medication.

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	055952	A. Building B. Wing	08/14/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation interview and record review the facility failed to: 1.Ensure an open date was placed on an open gallon of milk and an open bag of potato chips. 2.Ensure a bin of celery and multiple bags of hotdog buns were not expired.3.Ensure that chicken was defrosted safely, when the chicken was left in a tub of standing water while defrosting in the sink. 4.Ensure the sanitation bucket had sanitizer solution in it.These failures had the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another).Findings:During a concurrent observation and interview on 8/11/2025 at 8:15 a.m. with the Dietary Aide 2 (DA2) in the kitchen, a gallon of milk and a bag of potato chips did not have an open date label. A bin of celery with an expiration date of 8/10/2025 and multiple bags of hotdog buns dated 7/1/2025, 7/9/2025 and 8/3/2025 were observed. Observed two tubs of chicken thawing out in standing water. DA 2 stated there should be an open date on all food after it was opened so the residents will not get sick. DA 2 also stated that chicken needs to be defrosted under cold running water to ensure safe thawing temperatures to prevent salmonella (food born bacteria). DA 2 stated the celery and hotdog buns should have been thrown out because they were expired and not good for the residents to eat.During a concurrent observation and interview on 8/11/2025 at 9:45 a.m. with DA 1 the sanitation bucket was tested, the testing strip indicated there were 10 parts per million (ppm-unit of measure) of quats (sanitizer) solution in the sanitation bucket. DA 1 stated this was not right and should be between 50-100 PPM. The DS stated the residents were at risk for cross contamination and food borne illness when kitchen surfaces were not sanitized properly.During an interview on 8/14/2025 at 8:43 a.m., with the Dietary Supervisor (DS) , the DS stated after the food was opened there needs to be an open date label and food should not be served out of date to prevent food borne illness. The DS also stated that when thawing out meat there needs to always be cold running water to ensure safe thawing temperatures to prevent food borne illnesses. The DS also stated that the sanitation bucket should have 200-400 PPM of quats solution to prevent food borne illnesses from cross contamination.During a review of the Sanitation Bucket Log dated 8/2025, the sanitation bucket log indicated, change all buckets in the kitchen and retail every two hours and check concentration of one bucket. Must be 200-400 PPM manual mixing directions for Oasis 146 Quat Sanitizer: Mix two ounces of Oasis 146 quat sanitizer in 4 gallons of water. This will give you a sanitizer solution that is 200 -400 ppm.During a review of the facility's policy and procedure (P&P) titled Food Preparation, dated 2/2025 the P&P indicated All foods are prepared in accordance with the Food Drug Administration (FDA) food code. The cook thaws frozen items that require defrosting prior to preparation using one of the following methods completely submerging the item under cold water at a temperature of 70 degrees (Fahrenheit unit of temperature) or below that is running fast enough to agitate and float off loose ice particles.During a review of the facility's P&P titled Food receiving and storage, (undated), the P&P indicated Foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated with open and use by date and other containers must be dated and sealed or covered during storage.

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	08/14/2025

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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 observation, interview, and record review, the facility failed to: 1.Ensure the facility's activities of daily living tasks (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) binder containing residents' information was left unattended and open at the bedside table near a resident room.2.Ensure telephone orders were transcribed accurately a physician's wound treatment order for one of one resident (Resident 182).These failures had the potential to have unauthorized access to medical records and inaccurate wound treatment. Findings: 1.During an observation on 8/11/2025, at 1:21 p.m., Certified Nursing Assistant (CNA 6) documented on a binder located at the bedside table in front of a resident’s room. Certified Nursing Assistant (CNA 6) left the binder open and unattended when CNA 6 helped another resident. During an interview on 8/11/2025, at 1:28 p.m. with CNA 6, CNA 6 stated she was documenting the ADL tasks of residents including residents’ meals percentages, shower, toileting. CNA 6 stated CNA 6 should close the binder before helping a resident because the binder contains confidential health information of residents. During an interview on 8/11/2025, at 1:30 p.m. with CNA 7, CNA 7 stated CNS 6 should return the binder to the nursing station prior to CNA 6 helping a resident to ensure health information will remain confidential and safe. During an interview on 8/13/2025, at 3:26 p.m. with the Director of Nursing (DON), the DON stated CNA 6 should have closed the binder and put it back where in the nursing station. The DON stated residents’ privacy will be invaded and anyone in the facility can look and read the ADL binder that contained confidential health information of the residents. During a review of facility’s policy and procedure (P&P) titled, “HIPAA Security Measures” (undated), the P&P indicated “The facility will implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of resident’s identifiable information.” 2. During a review of Resident 182’s admission Record, the admission Record indicated the facility admitted the resident on 4/9/2025 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus type II (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 182’s Minimum Data Set (MDS- resident screening tool) dated 4/26/2025 indicated the resident has severely impaired cognition (ability to think and understand) and required substantial/maximal assistance from staff for rolling left to right, sit to stand and transfers. (continued on next page)

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	08/14/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of a physician’s telephone order (TO) dated 8/10/2025 at 3:07 p.m., the TO indicated ”Collagenase Ointment (medicine that removes dead tissue from wounds) 250 unit per gram (GM, unit of weight)) to be applied to the sacrococcyx (tailbone) topically (on the skin) every day shift for pressure ulcer (a skin injury that develops when prolonged pressure is applied to the same area of the body) for 14 days”. During an interview with Licensed Vocational Nurse (LVN) 5 on 8/14/2025 at 10:47 a.m., LVN 5 stated a dry dressing was always placed over a wound. LVN 5 stated “It was a mistake, and I forgot to write that in the telephone order.” LVN 5 stated if the dry dressing was not applied to the wound, the medication could leak and not get on the wound and not be effective”. During a record review of the facility’s policy and procedure titled,” Completeness and Accuracy of Documentation”, undated, “The facility shall ensure that all resident documentation is complete, accurate, timely, and reflects the care provided.”

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	055952	A. Building B. Wing	08/14/2025

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the arbitration (a form of dispute resolution where a neutral third party helps resolve a dispute between two or more parties) agreements were accurately completed for three of three sampled residents (Resident 29, 68, and 72). The facility failed to:1.Assess mental capacity (ability to make decisions) and provide information to Residents 29, 68, and 72 before signing the arbitration agreement. 2.Ensure the arbitration agreement forms are fully completed.This failure had the potential to result in Resident's 29, 68, and 72 not fully understanding his/her right to limit the opportunity to initiate judicial proceedings that challenge unfavorable decisions. Findings:During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).During a review of Resident 29's Minimum Data Set (MDS- a resident assessment tool) dated 12/30/2011, the MDS indicated Resident 29's cognition (ability to think, understand, learn, and remember) was intact. During a review of Resident 29's arbitration agreement dated 2/9/2016, the arbitration agreement was incomplete with no facility staff signature. During a review of Resident 68's admission Record, the admission Record indicated Resident 68 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68's cognition was severely impaired.During a review of Resident 68's arbitration agreement undated, the arbitration agreement was incomplete with no resident or resident representative signature. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and Parkinson's Disease (a progressive disease of the nervous system marked by tremors, muscular rigidity, and slow, imprecise movements). During a review of Resident 72's MDS dated [DATE], the MDS indicated Resident 72's cognition was moderately impaired. During a review of Resident 72's arbitration agreement undated, the arbitration agreement was incomplete with no resident or resident representative signature. During a concurrent interview and record review on 8/14/2025 at 7:44 a.m., with the Social Services Director (SSD) 1, SSD 1 validated Resident 29, 68, and 72's arbitration agreements were incomplete and therefore invalid. SSD 1 stated Resident 68 and 72's should not have been asked to sign an arbitration agreement because of their impaired cognition and not understanding what they were signing. During an interview on 8/14/2025 at 12:48 p.m., with the Director of Nursing (DON), the DON stated that a resident that was mentally incapable of understanding what they were signing, should not be asked to sign an arbitration agreement. The DON stated the arbitration agreement should be addressed with the resident representative or guardian because it was the resident right to sign an arbitration agreement and having them sign something they do not understand was going against their resident rights. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, undated, the P&P indicated, The facility must ensure that the agreement is explained to the resident and their representative in a form and manner that he or she understands, including in a language the resident and their representative understands. The resident acknowledges that he or she understands the agreement.

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	055952	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrance Care Center West, Inc	4333 Torrance Blvd Torrance, CA 90503

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA-develop and implement appropriate plans of action to correct identified quality deficiencies) failed to ensure effective oversight of the facility and implementation of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey. This failure resulted in the facility having repeat deficiencies in the areas of resident rights, advance directives, Medicare coverage notification, notice of transfer requirements, accuracy of assessments, implementing care plans, social services, pharmacy services, medication storage, and infection control and prevention. Findings:During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies: resident rights, advance directives, Medicare coverage notification, notice of transfer requirements, accuracy of assessments, implementing care plans, social services, pharmacy services, medication storage, and infection control and prevention.During an interview on 8/14/2025 at 2:30 p.m., with the Administrator (ADM), the ADM stated there are repeat deficiencies from the previous recertification survey. The ADM stated the facility should be stronger with their audits and increased review of the charts by the social workers. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI), undated, the P&P indicated, QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes, while involving residents and families in practical and creative problem solving. The QAA committee shall develop and implement appropriate plans of action to correct identified quality deficiencies. The QAPI plan will address the following elements: process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include tracking and measuring performance, establishing goals and thresholds for performance improvement, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices for two of five sampled residents (Resident 77 and 98) The facility failed to:1.Ensure Licensed Vocational Nurse (LVN 2) disinfected the medication tray used on Resident 77 before using the tray on another resident during medication pass.2.Ensure soiled gown of Resident 98 was handled and disposed in a sanitary manner.3. Ensure one of one resident (Resident 141) was not allowed to obtain clean linen from the laundry cart.These failures had the potential for cross contamination (transfer of harmful substances, like bacteria from one source to another) and spread of infection to the residents and staff.Findings: 1.During a review of Resident 77’s admission Records, the admission Records indicated Resident 77 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including paranoid schizophrenia (mental health condition where a person experiences intense paranoia[unrealistic distrust others or a feeling of being persecuted] and delusions[having false or unrealistic beliefs]) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 77’s Minimum Data Set (MDS- a resident assessment tool) dated 5/26/2025, the MDS indicated Resident 77 had an intact cognition (ability to think, understand, learn, and remember) and required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene, bed mobility, transfers, dressing and bathing. During a medication pass observation on 8/13/2025, at 8:13 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 used a medication tray that was not disinfected (cleaned something using a substance that kills germs and bacteria) after using them on Resident 19. Observed LVN 2 placed all the medication cups that contained medications to be administered to Resident 77 in the medication tray. Observed LVN 2 did not disinfect the medication tray after it was used on Resident 77. During an interview on 8/13/2025, at 2:22 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 admitted the medication tray used on Resident 77 was not sanitized or disinfected after it was used on Resident 19. LVN 2 stated she should have disinfected the medication tray after using and before using it on Resident 77 to prevent cross contamination that can lead to spread of infection. 2.During a review of Resident 98’s admission Record, the admission Record indicated Resident 98 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including unspecified dementia(a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and chronic obstructive pulmonary disease(COPD- group of lung disease that block the airflow which can cause difficulty of breathing). During a review of Resident 98’s MDS dated [DATE], the MDS indicated Resident 98 had moderately impaired cognitive skills and required supervision or touching assistance (helper provides verbal cues and /or contact guard assistance as resident completes the activity throughout the activity or intermittently) with dressing, toileting hygiene, oral hygiene, and transfer to and from a bed to chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/13/2025, at 8:13 a.m. with Certified Nursing Assistant (CNA 4), CNA 4 was holding a gown close to his chest then went to the shower room and stepped out of the room still holding the gown with his hands next to his body. CNA 4 stated the gown was dirty and came from Resident 98 room. CNA 4 stated there was no plastic bag and yellow barrel (laundry hamper) at the time when he was holding the dirty gown. CNA 4 stated dirty gown, and linens should be placed in a plastic bag and disposed of in the yellow barrel outside the resident room. CNA 4 stated dirty linens and gown should be away from his clothes to prevent the spread of infection. During an interview on 8/13/2025, at 10:27 a.m. with Infection Preventionist Nurse (IPN), IPN stated dirty linens, and gowns should be placed in a bag and disposed in the laundry barrel. IPN stated dirty linens and gowns should be away from staff’s clothes to prevent cross contamination and spread of infection among residents and staff members. IPN stated during the medication pass the licensed nurse should practice hand hygiene prior and after medication administration, disinfect blood pressure cuff and tray used on a resident to prevent spread of infection. IPN stated resident can get sick and contract the bacteria if the medication tray was not disinfected after use. During an interview on 8/13/2025, at 3:26 p.m. with the Director of Nursing (DON), the DON stated not disinfecting medication tray in between use on residents can spread infection among residents. The DON stated not handling dirty gowns and linens in a sanitary way can lead to the spread of germs to the residents , to himself (CNA 4) and other staff members. During a review of facility’s policy and procedure (P&P) titled, “Laundry,” undated, the P & P indicated soiled laundry will be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces and people. The P&P indicated all previously worn clothing and used linens of residents are potentially contaminated. During a review of facility’s P&P titled, “Cleaning and Disinfection of Resident-Care Equipment, ” undated, the P&P indicated “Resident-care equipment can be a source of indirect transmission of pathogens (any organisms that cause disease) and reusable resident-care equipment will be cleaned and disinfected to order to break the chain of infection.” 3.During an observation on 8/13/2025 at 9:05 a.m. Resident 141 was taking linen out of the clean linen cart located in the hallway across from room [ROOM NUMBER] B without staff assistance. Housekeeper (HK) who was in the hallway identified the resident as Resident 141. During an interview on 8/13/2025 at 9:22 a.m. with Housekeeper (HK), the HK stated Resident 141 took linen out of the clean linen cart without staff assistance. During an interview on 8/13/2025 at 9:27 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated nurses should assist residents in obtaining linens or towels. CNA 1 stated if residents are allowed to obtain their own towels, there could be an infection control issue. CNA 1 stated if residents are seen taking linens out of clean linen carts, residents are instructed to wait for staff to assist them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/2025 at 11:27 a.m. with the Director of Nursing (DON), the DON stated the Infection Prevention Nurse or Assistant Infection Prevention Nurse was responsible for ensuring infection control was met throughout the facility. The DON stated staff should assist in providing clean linen for residents because if residents are allowed to obtain their own linen, there will be cross contamination among other residents. During a record review of facility Policy and Procedure (P&P) titled “Handling Clean Linen” dated 2019 indicated “Guidelines for the storage of clean linen include, but are not limited to, the following: …d. Limit access to clean storage areas to staff.”

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide at least 80 square feet ({sq. ft} unit of measurement) per resident in multiple resident bedrooms for 20 out of 78 resident rooms. This deficient practice has the potential to result in an inadequate provision of safe nursing care and privacy for the residents. Findings:During a facility tour on 8/11/2025 at 10:08 a.m., observed that rooms 17, 18, 19, 20, 21, 23, 24, 25, 27, 29, 30, 31, 32, 33, 34, 35, 37, 38, 39, and 40, residents were able to move in and out of their rooms, and there was space for the beds, side tables, and resident care equipment. During an interview on 8/14/2025 at 2:30 p.m., with the Administrator (ADM), the ADM confirmed they had rooms less than the required 80 sq. ft per resident.During a review of the facility's request for a waiver of room size letter dated 7/24/2025, submitted by the ADM for 20 resident rooms was reviewed. The waiver request letter indicated there was adequate space for residents to get in and out of wheelchairs and residents have sufficient freedom for movement. The waiver request letter also indicated that the floor area of the affected room does not adversely affect the resident's health and safety and is in accordance with the special needs of the residents. The following rooms provided less than 80 sq. ft per resident: Rooms # of beds sq. ft 17 3 228. 1518 3 224.2519 3 216.6 20 3 214.721 3 224.223 3 22024 3 22025 3 22027 3 22029 3 22030 3 22021 3 22032 3 22033 3 22034 3 22035 3 22037 3 22038 3 234.639 3 234.640 3 226.2The minimum sq. ft for a three-bedroom room was 240 sq. ft.