STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Certified Nurse Assistant (CNA) 1 did not pinch the face or pull the hair of one of three sampled residents (Resident 1) while providing care to her on 3/23/2026. Following the allegation of abuse Resident 1 was not protected from CNA 1 during the investigation of her allegations. These deficient practices resulted in Resident 1 being fearful of CNA 1 who was then allowed to participate in a meeting where Resident 1 was present to discuss her allegations of abuse. These deficient practices compromised the integrity of the investigation, did not provide protective measures to Resident 1 during the investigation, minimized the severity of the allegations, and placed Resident 1 at risk for continued abuse, intimidation, guilt and fear of retaliation.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 had diagnoses including depression (a mood disorder that causes a persistent feeling of sadness or loss of interest), anxiety (feelings of fear, dread, or unease, often accompanied by physical symptoms like a rapid heart rate or tension) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's the Minimum Data Set ([MDS] a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 1 had moderate cognitive impairment (a brain condition that causes subtle changes in thinking and memory, resulting in more difficulty with these functions than is expected for someone's age). Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for toilet hygiene, showering, lower body dressing, and putting on and taking off footwear. During a review of Resident 1's History and Physical (H/P) dated 12/24/2025, the H/P indicated Resident 1 had a fluctuating capacity to understand and make medical decisions. During a review of the facility's undated Incident Investigation document, the Incident Investigation document indicated on 3/22/2026 Resident 1 reported CNA 1 was inappropriate with her during care when CNA 1 possibly rough handled her, pulled her hair and other actions perceived as harmful. During a telephone interview on 4/1/2026 at 10:30 a.m., Resident 1's Responsible Party (RP) stated on 3/23/2026 she notified the Administrator (ADM) by telephone that Resident 1 told her (RP) CNA 1 placed a pillow on her face, pinched her cheek, and covered her nose and mouth with his hands on 3/22/2026, and she (Resident 1) was fearful of CNA 1. On 3/24/2026, Resident 1 called her and allowed her to listen via her (Resident 1) phone to a meeting held with Resident 1, CNA 1, and a staff member (Human Resources [HR] representative). She heard CNA 1 apologize and say the incident (pinching Resident 1's cheek and pulling her hair while repositioning her) was a misunderstanding. Resident 1 sounded upset and said, he is lying. Later during the meeting Resident 1 accepted CNA 1's apology. The RP stated she felt the meeting between Resident 1 and CNA 1 was inappropriate because the facility placed Resident 1 and CNA 1 in the same room and Resident 1 sounded pressured to forgive CNA 1. During an interview on 4/1/2026 at 11:50 a.m., the ADM stated Resident 1's RP called her on 3/23/2026 at approximately 4:30 p.m. and reported that Resident 1 told her (RP) that CNA 1 placed a pillow on her face, pinched her cheek, handled her roughly, and engaged in other actions perceived as harmful. During a telephone interview on 4/2/2026 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12 a.m., CNA 1 stated he pinched Resident 1's cheek on 3/22/2026 because he wanted to show her endearment because it was her birthday. His intention was to show her a friendly gesture but admitted he did not act professionally. CNA 1 stated he did not explain to Resident 1 what he was doing while providing care to her. When he removed mucus from her nose she may have misunderstood what he was doing. CNA 1 stated when he repositioned Resident 1 in bed, he may have accidentally pulled her hair and caused a pillow to fall on her face. During an interview on 4/2/2026 at 9 a.m., Resident 1 stated CNA 1 pinched her cheek and covered her face with a pillow while providing care (3/22/2026) which made her to feel afraid of CNA 1. The facility held a meeting with her and CNA 1, during which CNA 1 asked for her forgiveness. Resident 1 stated she forgave him but did not want any further trouble and did not want CNA 1 to provide her care anymore. During an interview on 4/2/2026 at 3 p.m., the DSD stated on 3/23/2026 the ADM informed her of the allegation of abuse involving CNA 1 and Resident 1 and directed her to investigate. On 3/24/2026, she, the HR Representative and CNA 1 held a face-to-face meeting with Resident 1 and Resident 1's RP listened via phone. She believed it was important for CNA 1 to apologize and clear up what she felt was a misunderstanding because, in her view, Resident 1 and CNA 1 previously had a good relationship. She did not consider the facility's policy (Abuse Program) which indicated the resident and alleged perpetrator must be separated when she conducted the face-to-face meeting. During a review of the facility's Policy and Procedure (P/P) titled, Abuse Program Policy and Procedure revised 6/25/2025, the P/P indicated the facility has established a system to prevent not only abuse but also those practices and omissions, neglect and misappropriation of property, that if left unchecked can lead to abuse. Residents shall not be subjected to abuse by anyone, including but not limited to facility staff, or other residents. The facility shall make reasonable efforts to protect the residents from harm during the investigation process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH), when on 3/23/2026 one of three sampled resident's (Resident 1) Responsible Party (RP) notified the Administrator (ADM) that Certified Nurse Assistant (CNA) 1 pulled Resident 1's hair, pinched her face and placed a pillow over her head (3/22/2026) causing Resident 1 to be afraid of CNA 1. These deficient practices resulted in a delay in CDPH's investigation and had the potential for information pertinent to the allegations and investigation to be lost and/or forgotten.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 had diagnoses including depression (a mood disorder that causes a persistent feeling of sadness or loss of interest), anxiety (feelings of fear, dread, or unease, often accompanied by physical symptoms like a rapid heart rate or tension) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's the Minimum Data Set ([MDS] a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 1 had moderate cognitive impairment (a brain condition that causes subtle changes in thinking and memory, resulting in more difficulty with these functions than is expected for someone's age). Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for toilet hygiene, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's History and Physical (H/P) dated 12/24/2025, the H/P indicated Resident 1 had a fluctuating capacity to understand and make medical decisions. During a review of the facility's undated Incident Investigation document, the Incident Investigation document indicated on 3/22/2026 Resident 1 reported CNA 1 was inappropriate with her during care when CNA 1 possibly rough handled her, pulled her hair and other actions perceived as harmful. During a telephone interview on 4/1/2026 at 10:30 a.m., Resident 1's RP stated on 3/23/2026 she notified the Administrator (ADM) by telephone that Resident 1 told her (RP) that CNA 1 placed a pillow on her face, pinched her cheek, and covered her nose and mouth with his hands on 3/22/2026, and she (Resident 1) was fearful of CNA 1. On 3/24/2026, Resident 1 called and allowed her (RP) to listen via her (Resident 1) phone to a meeting held with Resident 1, CNA 1, and a staff member (Human Resources [HR] Representative) present. She heard CNA 1 apologize and say the incident (pinching Resident 1's cheek and pulling her hair) was a misunderstanding. Resident 1 sounded upset and said, he is lying. Later during the meeting Resident 1 accepted CNA 1's apology. The RP stated she felt the meeting between Resident 1 and CNA 1 was inappropriate because the facility placed Resident 1 and CNA 1 in the same room and Resident 1 sounded pressured to forgive CNA 1. During an interview on 4/1/2026 at 11:50 a.m., the ADM stated Resident 1's RP called her on 3/23/2026 at approximately 4:30 p.m. and reported that Resident 1 told her (RP) that CNA 1 placed a pillow on her face, pinched her cheek, handled her roughly, and engaged in other actions perceived as harmful. The ADM stated she did not report the allegations because she concluded abuse had not occurred and believed the incident was a misunderstanding between Resident 1 and CNA 1 and there was no harm to Resident 1. She felt confident in her decision not to report the allegations to law enforcement, the Ombudsman, or CDPH because she had been in her role for many years and understood the reporting requirements. During a telephone interview on 4/2/2026 at 12 a.m., CNA 1 stated he pinched Resident 1's cheek on 3/22/2026 because he wanted to show endearment for her birthday. His intention was to show her a friendly gesture but admitted he did not act professionally. CNA 1 stated he did not explain to Resident 1 what he was doing while providing care to her. When he removed mucus from Resident 1's nose she may have misunderstood what he was doing. CNA 1 stated when he repositioned Resident 1 in bed, he may have accidentally pulled her hair and caused a pillow to fall on her face. During an interview on 4/2/2026 at 9 a.m., Resident 1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated CNA 1 pinched her cheek and covered her face with a pillow while providing care (3/22/2026) which made her to feel afraid of CNA 1. Resident 1 stated she reported CNA 1's behavior to her RP but did not report it to anyone at the facility. During an interview on 4/2/2026 at 3 p.m., the DSD stated on 3/23/2026 the ADM informed her of the allegation of abuse involving CNA 1 and Resident 1 (3/22/2026). She did not report the incident to the appropriate agencies because the ADM was the abuse coordinator. During an interview on 4/2/2026 at 3:30 p.m., the Director of Nursing (DON) stated the ADM was the abuse coordinator and was responsible for immediately reporting any allegations of abuse to the appropriate agencies. All allegations of abuse should be reported to the Ombudsman, the CDPH and law enforcement immediately. Failure to report allegations of abuse violates the State and Federal regulations. During a review of the facility's Policy and Procedure (P/P) titled, Abuse Program Policy and Procedure revised 6/25/2025, the P/P indicated the facility. shall ensure. identification of staff members who would be responsible for initial reporting of alleged violations and reporting of results to the facility administrator or facility abuse coordinator, who shall in turn report such an incident to the required agencies.