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	08/15/2025

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 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. (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 0582 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 interview and record review, the facility failed to: 1. Ensure beneficiary notices were accurately completed for two of 3 sampled residents (Resident 18 and Resident 30).This deficient practice had the potential to result in residents and/or their responsible parties not being notified of the cost of services per day after benefits expired.Findings:a. During a review of Resident 18's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 18 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing) and osteoarthritis (a common joint disease that involves the breakdown of cartilage and underlying bone in joints). During a review of Resident 18's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 18's cognitive skills were moderately impaired. The MDS also indicated Resident 18 required maximal assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 18's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form, dated [DATE], the SNF ABN form indicated Resident 18's last day for Medicare Part A Skilled Services coverage was [DATE]. Resident 18's SNF ABN indicated as of [DATE], Resident 18 would have to pay out of pocket for continuation of care services provided by the facility. The SNF ABN form did not indicate which services Resident 18 received nor indicate the cost of services per day if Resident 18 was to pay out of pocket. b. During a review of Resident 30's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included anemia (a condition where the body does not have enough healthy red blood cells), type 2 diabetes, end stage renal disease (irreversible kidney failure) and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognitive (thinking) skills were intact. The MDS also indicated Resident 30 required partial assistance with ADLs. During a review of Resident 30's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form, dated [DATE], the SNF ABN form indicated Resident 30's last day for Medicare Part A Skilled Services coverage was [DATE]. Resident 30's SNF ABN indicated as of [DATE], Resident 30 would have to pay out of pocket for continuation of care services provided by the facility. The SNF ABN form did not indicate which services Resident 30 received nor indicate the cost of services per day if Resident 30 was to pay out of pocket. During a concurrent interview and record review, on [DATE], at 1:50 p.m., with the admission Coordinator (AC), the AC stated the purpose of the SNF ABN form was to inform residents of the specific care services received and the cost that would need to be paid out of pocket once a resident's Medicare A insurance expired. The AC stated Resident 18 and Resident 30's SNF ABN was incomplete. The AC stated the SNF ABN form was incomplete for Resident 18 and Resident 30 as no specific care areas were checked for each resident and the cost per day was not listed. The AC stated the risk of not completing a SNF ABN form could result in residents being unaware of the termination of their services, benefits and costs of services per day. During a review of the facility's policy and procedures (P&P), titled Beneficiary Notice of Non-Coverage, undated, the P&P indicated, It (SNF ABN) allows the resident (beneficiaries) to make informed decisions about whether to receive the service and potentially pay out-of-pocket, or to decline the service.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Minimum Date Set ([MDS] - a resident assessment tool) was completed accurately for two of 24 sampled residents (Residents 7 and 22) by failing to: 1. Ensure Resident 7's Neurontin (a medication used primarily used as anticonvulsant and for treatment of certain types of nerve pain) were encoded as anti-convulsant in the MDS assessment under Section N (N0415(k) High-Risk Drug Classes) medication. 2. Ensure Resident 22 had accurate documentation in the MDS assessment to reflect the use of Depakote ([anti-convulsant]- medication that controls abnormal electrical activity in the brain). This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Residents 7 and 22).Findings: 1.During a review of Resident 22’s admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 22’s diagnoses included dementia (a progressive state of decline in mental abilities), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and mood disorder. During a review of Resident 22’s History and Physical (H&P), dated 6/19/2025, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 22’s Minimum Data Set (MDS – a resident assessment tool), dated 7/24/2025, the MDS indicated Resident 22 had a moderate cognitive (ability to reason and understand) impairment. The MDS indicated Resident 22 was not taking an anti-convulsant. Resident 22 needed maximal assistance (helper does less than half the effort) with bathing, touching assistance with upper body dressing, and moderate assistance with lower body dressing. During a review of Resident 22’s Order Summary, dated 8/1/2025, the summary indicated on 6/18/2025 the physician entered an order for Depakote to be given once a day. During a concurrent interview and record review on 8/14/2025 at 12:51 p.m. with the Minimum Data Set Nurse (MDSN), Resident 22’s MDS was reviewed. The MDS indicated Resident 22 was not taking an anti-convulsant. The MDSN stated the MDS should reflect the residents’ status as of the date it was submitted. Resident 22 initially started taking Depakote on 6/19/2025 and the MDS was completed on 7/24/2025. The MDSN stated Depakote should be coded on the MDS as an anti-convulsant. The MDS submitted on 7/24/2025 was erroneous. During a review of the facility’s policy and procedure (P&P), titled “Certifying Accuracy of Resident Assessment, no date, the P&P indicated any person completing a portion of the MDS must sign and certify accuracy of the portion of the assessment. 2.During a review of Resident 7’s admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 7 was admitted to the facility on [DATE]. Resident 7’s diagnoses included difficulty in walking, neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7’s History and Physical (H&P), dated 5/25/2025, the H&P indicated, Resident 7 had fluctuating capacity to understand and make decisions. During a review of Resident 7’s Minimum Data Set ([MDS] – a resident assessment tool), dated 5/29/2025, the MDS indicated, Resident 7 had the ability to make self-understood and understand others. The MDS indicated, Resident 7’s cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 7 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) from staff with eating and oral hygiene. During a review of Resident 7’s Order Summary Report (a document containing active orders) dated 8/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 5/22/2025 for Resident 7 to start on Neurontin (a medication used primarily used as anticonvulsant and for treatment of certain types of nerve pain) 300 milligrams ([mg] – metric unit of measurement, used for medication dosage and/or amount) to give one capsule every three times a day (9 a.m., 1 p.m., and 5 p.m.) for neuropathy. During a concurrent interview and record review on 8/13/2025 at 1:15 p.m., with the Minimum Data Set Nurse (MDSN), Resident 7’s MDS assessment, dated 5/29/2025, was reviewed. The MDSN stated Resident 7’s MDS was completed inaccurately. The MDSN stated Resident 7’s MDS, Section N (N0415(k) High-Risk Drug Classes) should have a checked mark since Resident 7 is on Neurontin which is classified as anticonvulsant medication. The MDSN stated Resident 7 started the Neurontin on 5/22/2025. The MDSN stated Resident 7 received Neurontin on 5/23/2025, 5/24/2025, 5/25/2025, 5/26/2025, 5/27/2025, and 5/28/2025. The MDSN stated the MDS section N (Medications) look back period (the specific time frame within which certain resident conditions and events are assessed) was 7 days before the completion date. The MDSN stated Resident 7’s use of Neurontin as anticonvulsant medication should have been captured and encoded within that assessment period which is 5/29/2025. The MDSN stated the coding of medications in the MDS section N should be based on the drug classification. The MDSN stated it is important to code accurately the MDS section N because it would reflect the correct drug regimen of the resident. The MDSN stated inaccuracy of MDS assessment could affect the care planning of the resident. During a review of the facility’s undated policy and procedure, titled “Certifying Accuracy of Resident Assessment,” the P&P indicated, “Any person completing the portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign the accuracy of that portion of the assessment”.

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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:1. Ensure care plan intervention was implemented to monitor signs and symptoms of urinary tract infection ([UTI] - an infection in the bladder/urinary tract) for one of four sampled residents (Resident 75) who had a foley catheter (a hollow tube inserted into the bladder to drain or collect urine). This deficient practice placed Resident 75 at risk for unidentified UTI that would lead potentially to life-threatening condition. Findings:During a review of Resident 75's admission Record (front page of the chart that contains basic information of the resident), the admission Record indicated, Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 75's diagnoses included obstructive uropathy (a blockage in the urinary tract that prevents normal urine flow), malignant neoplasm of bladder (type of cancer that develops in the bladder, the organ that stores urine), and generalized muscle weakness. During a review of Resident 75's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/21/2025, the MDS indicated, Resident 75 sometimes had the ability to make self-understood and understand others. The MDS indicated, Resident 75's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 75 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, toileting hygiene, and upper body dressing. The MDS indicated, Resident 75 had indwelling (inside your body) catheter. During a review of Resident 75's care plan, titled Needs indwelling catheter due to obstructive uropathy, dated 8/19/2024, indicated goal for resident not to develop UTI, until next review in three months. The care plan intervention included to monitor for sign and symptoms of UTI such as chills, fever, note sediments build-up, blood clot, bladder distention, and scanty concentrated foul urine output. During a concurrent observation and interview on 8/13/2025 at 2:26 p.m., with Treatment Nurse 1 (TN 1), in Resident 75's room, TN 1 stated Resident 75 had yellow/white sediments (solid particles which can include crystals and bacteria) in his urine present in the foley catheter tubing. TN 1 stated presence of sediments in the urine is one of the signs and symptoms of UTI. TN 1 stated Resident 75 is at risk for UTI because he has an indwelling foley catheter. TN 1 stated there is no documentation on Resident 75's Treatment Administration Record ([TAR] - a daily documentation record used by a licensed nurse to document treatments given to a resident) indicating he was monitored for signs and symptoms of UTI. During a concurrent interview and record review on 8/13/2025 at 2:52 p.m., with the Director of Nursing (DON), Resident 75's clinical records were reviewed. The DON stated there were no clinical nursing documentation by licensed nursing staff that Resident 75 was monitored for signs and symptoms of UTI. The DON stated it is very important to follow and implement the care plan intervention so resident's UTI could be treated early. The DON stated severe UTI could lead to sepsis (a life-threatening blood infection) that would likely require hospitalization. During a review of the facility's undated policy and procedure (P&P), titled Comprehensive Person-Centered Care Plans, the P&P, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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:1. Ensure medications were not left at the bedside for one of 24 sampled residents (Resident 1). This deficient practice had the potential to result in Resident 1's not taking his prescribed medications that would lead to medical complications. Findings:During a review of Resident 1's admission Record (front page of the chart that contains basic information of the resident), the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), hemodialysis ([HD] - a treatment to cleanse the blood of wastes and extra fluids artificially through machine when the kidney(s) have failed), and dementia (a progressive state od decline in mental abilities). During a review of review of Resident 1's History and Physical (H&P), dated 5/28/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/6/2025, the MDS indicated, Resident 1 had the ability to make self-understood and understand others. The MDS indicated, Resident 1 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene. During an observation on 8/12/2025 at 11:08 a.m., in Resident 1's room, found 4 medications placed in a cup at bedside table. Resident 1 stated the nurse left those medications when she came and administered his morning medications at around 9:00 a.m. During an interview on 8/12/2025 at 11:18 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she complied with Resident 1's request to leave the medications at bedside. LVN 1 stated the standard of practice is to stay with the resident until he took all his medications. LVN 1 stated the risk of leaving medications at bedside could result in the resident not taking the medication. During an interview on 8/13/2025 at 10:10 a.m., with Registered Nurse 1 (RN 1), RN 1 stated no medications should be left at resident's bedside unattended. RN 1 stated it is important to administer all the prescribed medications to the resident. RN 1 stated the health and safety of Resident 1 would be jeopardized (at risk of harm) if he missed any of his medications. During an interview on 8/14/2025 at 1:40 p.m., with the Director of Nursing (DON), the DON stated Resident 1 is not safe to administer his own medications and the licensed nursing staff should watch the resident taking his medications. The DON stated the physician prescribed medications to residents to treat their existing condition and to prevent any complications. The DON stated there would be an adverse effect (undesirable or harmful outcome) on Resident 1's health condition if he would miss his prescribed medications. During a review of the facility's undated policy and procedure (P&P), titled Standards of Practice, the P&P, indicated Standards ensure nurses provide safe and effective care, minimizing risks and promoting positive patient outcomes. During a review of the facility's P&P, titled Quality of Care,, the P&P indicated, Quality of care is governed by regulations focused on resident well-being and safety.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one of one resident (Resident103) with resident-centered activities consistent with the resident's care plan. This deficient practice had the potential to result in Resident 103 expressing feelings of sadness and isolation. Findings:During a review of Resident 103's admission Record, the admission Record indicated the facility admitted the resident on 12/17/2024, and was re-admitted on [DATE] with diagnoses including of cerebral infarction (brain tissue dies due to lack of blood supply), cardiac arrest (loss of heart function, breathing and consciousness), anoxic brain damage (brain deprived of oxygen) aphasia (difficulty speaking) and scoliosis (curvature of the spine).During a review of Resident 103's History and Physical (H&P), dated 6/23/2025, the H&P indicated Resident 103 had the capacity to understand and make decisions.During a review of Resident 103's Activities Care Plan dated 8/04/2025, Resident 103 liked watching TV, joining small groups, listening to music, and exercising. The care plan interventions were for staff to provide 1:1 (one to one) socialization, providing iPad for music, listening pleasure and sensory stimulation for sound, touch and smell. During a concurrent observation and interview on 8/13/2025 at 10:15 a.m. with Resident 103, Resident 103 was unable to verbalize responses but was able to acknowledge questions via head gestures.During an observation and interview on 8/14/2025 at 2:30 p.m. with the Activity Director (AD), in Resident 103's room, the AD stated Resident 103 watches television (TV), listens to music inside the room via iPad and exercises in room or the Activity Room. There was one TV in Resident 103's room positioned across from Resident 103 facing the roommate. Resident 103 was observed laying on bed staring straight up. The AD stated Resident 103 was not watching TV and would have feelings of sadness if he was unable to watch TV. During an interview on 8/13/2025 at 2:30 p.m. with the Director of Staff Development (DSD), the DSD stated residents are offered resources and activities to be engaged by the Activity Director. The DSD stated nursing staff can assist and engage with residents, but the responsibility with activities was the Activity Director.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 resident (Resident 10) had a low air loss mattress on the appropriate setting.This deficient practice had the potential for Resident 10 to develop a pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence).Findings:During a review of Resident 10's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 10 was admitted on [DATE] with diagnoses that included malignant neoplasm of the bladder (bladder cancer), absence of right upper limb below elbow, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and intervertebral disc degeneration (a condition where the spinal discs, which act as cushions between vertebrae, break down and lose their ability to absorb shock effectively).During a review of Resident 10's History and Physical (H&P), dated 4/10/2025, the H&P indicated Resident 10 did not have the ability to understand and make decisions.During a review of Resident 10's Care Plan, dated 4/14/2025, the Care Plan Report indicated Resident 10 had the potential for skin breakdown and interventions included the use of pressure-redistribution mattress.During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 10 used a pressure reducing device in bed and required moderate assistance in mobility. The MDS also indicated Resident 10 was usually able to make himself understood and usually able to understand others and had moderately impaired cognition (ability to reason, understand, remember, judge, and learn).During a review of Resident 10's Order Summary Report dated 8/15/2025, the Order Summary Report indicated Resident 10 had an order to apply a pressure foam mattress every day in bed.During a concurrent observation and interview on 8/12/2025 at 12:15 p.m., Resident 10 was observed to be lying on a low air loss mattress (LALM). Resident 10 stated he did not know what the LALM was for. The low air loss mattress dial was set at 320 pound (lb.- unit of weight) and was switched on to the static mode. Resident 10 pointed to a bony area by his elbow and showed his knee and leg and pointed out the bony parts of his body and said he did not have any skin issues, and the bony area is because he had cancer.During a concurrent observation and interview on 8/12/2025 at 3:58 p.m. with Treatment Nurse (TN) 1, TN 1 stated there are various reasons why a resident needs to have a LALM but usually it is because they are at risk of developing a pressure ulcer or already have one. TN 1 looked at LALM setting for Resident 10 and stated it was set at 320 lbs. but that was incorrect because it should be set between 100- 120 lbs. which would be more reflective of Resident 10's weight. TN 1 further stated the LALM is currently set to static mode and not alternating but was unsure which setting he should have been on. TN 1 stated it was important for the settings to be set correctly to reduce pressure ulcers.During an interview on 8/15/2025 at 12:14 p.m. with the Director of Staff Development (DSD), the DSD stated the LALM should be set according to the residents' correct weight to prevent pressure injuries. If it is set at the incorrect weight, it would not be providing the appropriate pressure relief. During a video review of the instructional video by the manufacturing company, Medline, titled A10 and A20 Low Air Loss Mattress System- Instruction for use, dated 6/26/2023, at https://vimeo.com/848769965, the instructional video indicated when preparing the mattress for a resident, turn the dial to the correct weight of the resident. The pump should be in static mode when placing the resident on the mattress. Once placed on mattress, switch from static mode to alternating mode to enable alternating pressure therapy.During a review of the facility's policy and procedure (P&P), titled Support Surface Guidelines, undated, the P&P indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface and support surfaces are modifiable and individual resident needs differ.

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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: 1. Ensure one of two sampled residents (Resident 34) oxygen delivery equipment was labeled and changed in accordance with the current accepted professional standards of practice. 2. Ensure one of five sampled residents' (Resident 59) tubing for the nebulizer machine (medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs) was changed every seven days per facility protocol. These deficient practices had the potential for Resident 34 and Resident 59 to experience complications such as infection associated with oxygen therapy.Findings: 1. During a review of Resident 34’s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 34 was admitted on [DATE] with diagnoses that included end stage renal disease (End Stage Renal Disease-irreversible kidney failure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 34’s History and Physical (H&P), dated 6/23/2025, the H&P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34’s Minimum Data Set (MDS – a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 34 had the ability to make themselves understood and had the ability to understand others. The MDS further indicated Resident 34 was cognitively intact (ability to reason, understand, remember, judge, and learn) and did not have limitations in range of motion of the upper and lower extremities (related to the arms and legs). During a review of Resident 34’s Care Plan Report dated 6/24/2025, the Care Plan Report indicated Resident 34 had an episode of being short of breath and interventions included to administer oxygen as prescribed. During a review of Resident 34’s Order Summary Report dated 8/15/2025, the Order Summary Report indicated Resident 34 had an order for oxygen via nasal cannula as needed for shortness of breath. During an observation on 8/12/2025 at 1:45 p.m. in Resident 34’s room, an oxygen concentrator (a machine that delivers supplemental oxygen to an individual) with a nasal cannula (a small plastic tube, which fits into the person’s nostrils for providing supplemental oxygen) with a humidifier (a medical device to add moisture to supplemental oxygen) attached were by Resident 34's bedside. The nasal cannula was dated 7/13/2025 and the humidifier did not have a date on it. During an interview on 8/14/2025 at 8:52 a.m. with Resident 34, Resident 34 stated the oxygen machine next to him has been there for several weeks now and did not use it in the past two weeks. During a concurrent observation and interview on 8/15/2025 at 9:09 a.m. with Registered Nurse (RN) 1, Resident 34’s nasal cannula and humidifier was observed at the bedside. RN 1 stated the date on the nasal cannula was dated 7/13/2025 and the humidifier did not have a date on it. RN 1 stated the nasal cannula and humidifier need to be labeled with a date on it and should be changed out at least once a week and if not, it could potentially cause an infection (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	08/15/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 59’s admission Record, the admission Record indicated Resident 59 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 29’s diagnoses included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 59’s History and Physical (H&P), dated 10/22/2024, the H&P indicated Resident 59 did not have a cognitive (ability to reason and understand) impairment. During a review of Resident 59’s Minimum Data Set (MDS – a resident assessment tool), dated 7/15/2025, the MDS indicated Resident 59 is usually able to make herself understood and can usually understand others. Resident 59 was dependent (helper does all the effort) on staff for bathing and dressing the lower body. Resident 59 needed maximal assistance (helper does more than half the effort) with dressing the upper body. During a review of Resident 59’s Order Summary, dated 8/15/2025, the summary indicated on 10/15/2024 the physician entered an order for Budesonide Inhalation Suspension (mediation inhaled into the lungs through a nebulizer to reduce inflammation) to be inhaled two times a day. During a review of Resident 59’s care plan, dated 7/25/2023, the care plan indicated Resident 59 was at risk for infection. The care plan goal indicated the facility would minimize the risks of acquiring a viral infection through infection control precautions During a review of Resident 59’s medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated August 2025, the MAR indicated Resident 59 was given Budesonide Inhalation Suspension at 9:00 a.m. and 5:00 p. m. August 1st- August 12th. During a concurrent observation and interview on 8/14/2025 at 2:25 p.m. with Licensed Vocational Nurse (LVN) 2 at the bedside of Resident 59, Resident 59’s nebulizer tubing was observed with a date of 8/3/2025. The tubing was still plugged into the nebulizer machine. The mask attached to the tubing was dated 8/10/2025. LVN2 stated the nebulizer tubing should be changed every Sunday. The tubing should have been changed on 8/10/2025. The tubing should be changed every 7 days to prevent infection. During a review of the facility’s policy and procedure (P&P), titled “Administering Medications through a Small Volume (Handheld) Nebulizer”, no date, the P&P indicated staff will change equipment and tubing every seven days. The equipment will be stored in a plastic bag with the resident’s name and date on it.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an effective pain management on one of one sampled resident (Resident 14) by failing to:1. Ensure Resident 14's pain level was assessed after administering pain medication. This deficient practice placed Resident 14 at risk for inadequate pain relief and delay of care. Findings: During a review of Resident 14's admission Record (front page of the chart that contains basic information of the resident), the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included chronic (something that continues over an extended period of time) back pain, generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and generalized muscle weakness. During a review of Resident 14's History and Physical (H&P), dated 7/3/2025, the H&P indicated, Resident 14 had the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set ([MDS] - a resident assessment tool), dated 7/7/2025, the MDS indicated, Resident 14 had the ability to make self-understood and understand others. The MDS indicated, Resident 14 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 14 was totally dependent (helper does all of the effort) from staff with toileting hygiene, upper and lower body dressing. During a review of Resident 14's Order Summary Report (a document containing active orders) dated 8/14/2025, the Order Summary Report indicated, the physician placed a telephone order on 7/15/2025 for Resident 14 to start on Tramadol (controlled pain medication) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to give one tablet every 12 hours as needed for moderate pain (4-6/10) to severe pain (7-10). During a review of Resident 14's care plan, titled At risk for pain and episode of pain, due to chronic back pain, osteoarthritis, and history of spinal injury, dated 7/3/2025, indicated goals for resident to be comfortable, pain free daily, and pain will be relieved within one hour upon onset, until next review in three months. The care plan interventions included to administer medication as ordered and monitor effectiveness. During a review of Resident 14's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications given to a resident), dated 8/14/2025 at 10:10 a.m. indicated, Resident 14 was given tramadol 50mg one tablet for severe pain (7/10). During an interview on 8/14/2025 at 11:40 a.m. with Resident 14, Resident 14 stated he still has back pain despite receiving tramadol two hours ago. Resident 14 stated his current pain scale is 6/10 (moderate pain), described pain as aching and constant. Resident 14 stated the nurse did not come back to check on him after giving pain medication. During an interview on 8/14/2025 at 12:34 p.m., with Registered Nurse 2 (RN 2), RN 2 stated she administered tramadol 50 mg one tablet to Resident 14 today at 10:10 a.m. RN 2 stated she did not reassess Resident 14's pain level after administering pain medication. RN 2 stated she should have reassessed Resident 14's pain level at least 30 minutes to an hour after administering the tramadol to ensure that the medication was appropriate and effective to the resident and to make necessary adjustment on his pain management plan. RN 2 stated there would be an effect of Resident 14's physical function if his pain is not properly controlled. During an interview on 8/14/2025 at 2:05 p.m., with the Director of Nursing (DON), the DON stated it is very important to assess resident's pain level before and after administration of pain medication to assess the effectiveness of the medication and to observe side-effects (an effect of a drug or other type of treatment that is in addition to or beyond its desired effect). The DON stated ineffective pain management would result to suffering to the resident that would affect his quality of life. During a review of the facility's undated policy and procedure (P&P), titled Pain Assessment and Management, the P&P, indicated The pain management interventions shall be consistent with the resident's goals for treatment, and such goals will be specifically defined and documented.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who received hemodialysis ([HD] - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment received care in accordance with standards of practice for one of five sampled residents (Resident 1) by failing to:1. Communicate to dialysis center staff regarding Resident 1's change of condition. This deficient practice had the potential to result in a delay or lack of coordination of dialysis care and services to Resident 1. Findings:During a review of Resident 1's admission Record (front page of the chart that contains basic information of the resident), the admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), hemodialysis ([HD] - a treatment to cleanse the blood of wastes and extra fluids artificially through machine when the kidney(s) have failed), and dementia (a progressive state od decline in mental abilities). During a review of review of Resident 1's History and Physical (H&P), dated 5/28/2025, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/6/2025, the MDS indicated, Resident 1 had the ability to make self-understood and understand others. The MDS indicated, Resident 1 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 1's Order Summary Report (a document containing active orders) dated 8/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 5/25/2025 for Resident 1 to have dialysis treatment 3x/week every Monday, Wednesday, and Friday. During a review of Resident 1's Change of Condition Evaluation (a communication tool used to communicate a resident's change of condition), dated 8/10/2025, the Change of Condition Evaluation indicated, Resident 1 had an episode of confusion. During a concurrent interview and record review on 8/14/2025 at 12:22 p.m., with Registered Nurse 2 (RN 2), Resident 1's Dialysis Communication Record, dated 8/11/2025 and 8/13/2025, were reviewed. RN 2 stated the licensed nursing staff did not communicate and did not document in the Dialysis Communication Record regarding Resident 1's change of condition for episode of confusion that occurred in the facility on 8/10/2025. RN 2 stated the Dialysis Communication Record is a tool among facility and dialysis staff to communicate resident's condition. RN 2 stated it is very important to communicate and collaborate Resident 1's plan of care and change of condition to dialysis staff so they could manage resident properly during dialysis treatment and to prevent delay of care. During an interview on 8/14/2025 at 1:48 p.m., with the Director of Nursing (DON), the DON stated any change of condition of resident that occurred in the past 24 hours should be communicated immediately to dialysis center staff so they could inform the nephrologist (medical doctor who specializes in the diagnosis, treatment, and management of kidney diseases and conditions) and ask for any treatment recommendation. The DON stated it is essential to maintain an open communication between facility and dialysis staff to meet the needs of the resident and for continuity of care. During a review of the facility's undated policy and procedure (P&P), titled Communication to Dialysis Center, the P&P, indicated Communication between facility and dialysis facilities is crucial for the well-being of residents receiving dialysis. The P&P also indicated a structured process for handoffs during patient transitions between facilities is crucial that includes a documented communication tool that captures essential information like vital signs, medications, any changes in the resident's condition.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 3) received Furosemide ([diuretic]- medication used to remove excess fluid from the body) by the route ordered by the physician.This deficient practice had the potential for Resident 3 to have an adverse effect (bad outcome) after receiving the medication.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 3's diagnoses included congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and obesity.During a review of Resident 3's History and Physical (H&P), dated 1/30/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 7/22/2025, the MDS indicated Resident 3 had the ability to express ideas and understand others.During a review of Resident 3's Order Summary, dated 8/1/2025, the summary indicated on 7/21/2025 the physician entered an order for Furosemide Oral Solution 2 ml (unit of measure) by mouth one time a day.During a review of Resident 3's care plan, dated 1/27/2024, the care plan indicated Resident 3 had the potential for edema due to heart failure. The interventions indicated staff would administer diuretics as prescribed.During an observation on 8/14/2025 at 8:55 a.m. at the bedside of Resident 3, Registered Nurse (RN) 2 was observed administering Furosemide into Resident 3's feeding tube (a flexible plastic tube placed into your stomach or bowel to help you get nutrition when you're unable to eat). During a concurrent interview and record review on 8/14/2025 at 9:05 a.m. with RN2, Resident 3's physician orders were reviewed. The orders indicated Furosemide was ordered to be given by mouth. RN2 stated if a medication is ordered to be given by mouth, it should given by mouth. If you don't give a medication by the correct route the resident can have ill effects.During a review of the facility's policy and procedure (P&P), titled Administering Medications, no date, the P&P indicated medications are administered in accordance with the prescriber orders.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 27) had a Hemoglobin A1C ([HgA1C] - a blood test that measures the average blood sugar level over the past two to three months) completed every three months per physician's order.This deficient practice resulted in inadequate monitoring of Resident 27's diabetes ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 27's diagnoses included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated 7/25/2025, the MDS indicated Resident 27 was able to express ideas/wants and able to understand others. The MDS indicated Resident 27 was dependent (helper does all the effort) on staff for dressing and bathing.During a review of Resident 27's Order Summary, dated 8/1/2025, the summary indicated on 2/27/2024 the physician entered an order for a HgA1C to be completed every three months. During a review of Resident 27's care plan, dated 11/03/2018, the care plan indicated Resident 27 had a potential for hypoglycemia or hyperglycemia due to diabetes mellitus. The interventions indicated staff would monitor ordered labs and report abnormal results.During a concurrent interview and record review on 8/14/2025 at 2:40 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 27's lab results were reviewed. The results indicated the HgA1C was completed on 8/16/2024 and 3/25/2025. LVN3 stated the HgA1C was not completed as ordered. The HgA1C should have been completed on 6/25/2025. LVN3 stated the physician ordered the test to monitor the status of the resident's diabetes. Since the test was not completed as ordered you don't know the status of the resident's diabetes. The resident may need to have medications adjusted and you wouldn't know.During a review of the facility's policy and procedure (P&P), titled Request for Diagnostic Services, no date, the P&P indicated orders for diagnostic services will be promptly carried out as instructed by the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when:1. 1 box of Boost (nutritional drink)supplement with 19 brick pack remaining were stored in the dry storage area with no date and label.2. 1 box of chocolate fat free ice cream with 26 cups remaining were stored in freezer #1 with no date and label.3. 1 box of [NAME] house honey wheat roll dough were stored in freezer #1 with no date and label.4. 1 box of liquid whole eggs pasteurized with 11 brick pack remaining were stored in refrigerator #1 with no date and label. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 101 out of 106 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on 8/12/2025 at 8:22 a.m., with Dietary Aide 1 (DA 1) in the dry storage area, there were 1 box of Boost supplement with 19 brick pack remaining with no date and label. DA 1 stated all food items in the dry storage area should have labeled with the delivery date, the date it was opened, and the best buy date. DA 1 stated the risk for giving expired food items to resident is food poisoning. 2. During a concurrent observation and interview on 8/12/2025 at 8:34 a.m., with the Dietary Service Supervisor (DSS), in the freezer #1, there were 1 box of chocolate fat free ice cream with 26 cups remaining with no open date. The DSS stated 1 box of chocolate fat free ice cream was delivered on 8/5/2025 but it was unknow when the box was opened since it was not labeled with an open date. The DSS stated it is important to label and date so we can keep track of the food items that need to be discarded. 3. During an observation on 8/12/2025 at 8:36 a.m. in the freezer #1, found 1 box of [NAME] house honey wheat roll dough with no label with an open date. 4. During an observation 8/12/2025 at 8:49 a.m., in the walk-in-refrigerator #1, found 1 box of liquid whole eggs pasteurized with 11 brick pack remaining with no label with an open date. During an interview on 8/12/2025 at 8:54 a.m., with the DSS, the DSS stated the acceptable standard of practice was to label and date all the food items in the kitchen. During a review of the facility's undated policy and procedure (P&P) titled, Labeling and Dating of Foods, the P&P indicated, Label with received by date upon receiving, once opened with an open date, and use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to:Ensure a comprehensive water management program was in place.Ensure the Infection Prevention Control Program (IPCP) including standards, polices, and procedures were current, based on national standards, and reviewed at least annually.Ensure gloves were worn while disinfecting the bedside table and prepping wound care supplies for one of one sampled resident (Resident 5).These deficient practices had the potential for staff to follow outdated policies, placing residents and staff at risk for cross contamination and transmission of diseases within the facility.Findings: 1. During a review of the facility’s Water Management Program binder provided by the Infection Prevention Nurse (IPN), the Water Management Program binder only contained the results of randomly selected water samples collected in the facility to test for Legionella (a bacteria that causes a severe form of infection in the lungs). During a review of the maintenance binder from the Maintenance Supervisor (MS), the maintenance binder only had written daily water temperature checks in random residents’ rooms, laundry machine, and dishwasher. During an interview on 8/14/2025 at 10:50 a.m. with the IPN, the IPN stated the facility’s Water Management Program binder and the water temperature checks from the MS are what they have as part of their water management program. During an interview on 8/14/2025 at 3:01 p.m. with the IPN and MS, the IPN stated their water management program plan was to collect water samples from various sources throughout the facility annually and test if there was Legionella. The IPN stated the administrator, the MS, and herself have copies of the report. The MS stated his maintenance binder had daily water temperature checks of two random residents’ rooms sink, the dishwasher, and the laundry machine daily. The MS stated there was nothing else in his binder regarding checks of other areas inside or outside the facility where water may collect or come out of. The MS and IPN stated his binder did not contain paperwork that explained what should be done in the event temperature falls out of range, the areas inside or outside the facility where water comes out of or collects, or diagrams of how hot and cold water flowed throughout the facility. The MS and IPN stated his binder did not contain diagrams of the equipment where water may pass through or an inspection of the equipment. The IPN stated the facility did not have a water management team that met on a routine basis, nor was there a system in place to identify situations that could lead to legionella growth such as the buildup of biofilm and/or sediments. The IPN stated it was important to ensure the water systems in the facility were within acceptable range so the facility would know what corrective action to take to correct it. The IPN stated if the equipment or water were not clean or out of range, it could lead to a growth of waterborne pathogens (microorganisms that could cause disease that are transmitted through water). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility’s policy and procedure (P&P) titled “Legionella Water Management Program”, undated, the P&P indicated as part of the infection prevention and control program, the facility had a water management program which is overseen by the water management team and consists of at least the infection preventionist, administrator, medical director, director of maintenance and director of environmental services. The P&P indicated the water management program should include the following elements: an interdisciplinary water management team, detailed description and diagram of the water system in the facility, identification of areas in the water system that could encourage growth and spread of Legionella or other waterborne bacteria, identification of situations that can lead to Legionella growth, specific measures to control introduction and/or spread of legionella, the control limits that are acceptable and monitored, a diagram of where control measures are applied, a system to monitor control limits and the effectiveness of control measures, and a plan for when control limits are not met or control measures are not effective. 2. During a review of the facility’s policies and procedures (P&P) as part of their Infection Prevention Control Program (IPCP), the P&P titled “Vaccination of Facility Staff”, undated, was reviewed. The P&P indicated all staff must be fully vaccinated and received a booster for COVID-19 (a contagious disease caused by a virus) recommended by the World Health Organization and exemptions are made for those with religious beliefs or medical conditions that may be affected by the vaccine and provide a copy of reasonable evidence or claim for the exemption. The P&P further indicated staff who are exempt or incompletely vaccinated, need to test for COVID-19 twice a week and wear an N95 mask (a face mask that filters small particles) at the workplace. During a concurrent interview and record review on 8/15/2025 at 10:15 a.m. of the facility’s IPCP with the administrator (ADMN), the ADMN stated all their policies and procedures are reviewed and approved altogether at one time by the heads of department along with their consultants typically at the beginning of the year. The ADMN stated each department had their own binder of P&P to review that relates to their department and significant changes are discussed together. The ADMN stated, if necessary, an in-service will be held for facility staff to inform them of changes. The ADMN reviewed the P&P titled “Vaccination of Facility Staff” and stated staff members are no longer mandated to receive the COVID-19 vaccine to work, and staff and residents had the right to refuse the vaccine. The ADMN further stated staff who do not want the vaccine do not need to provide evidence why they do not want the vaccine, and those who do not receive the vaccine also did not have to be tested twice a week for COVID-19 or must wear a N95 mask in the facility. The ADMN stated there must have been an oversight as to why this P&P was not updated to reflect the current regulations and it was important to have P&P updated to reflect current practices to ensure the safety of staff and residents. During a review of the facility’s P&P titled “Facility Policy Review”, undated, the P&P indicated a facility process to evaluate the effectiveness and relevance of a specific policy or set of policies and ensures that policies remain current, accurate and aligned with organizational goals and legal requirements. The purpose of policy reviews was to maintain relevance as policies could become outdated due to changes in regulations, technology, or business needs. Reviews ensure policies remain current and applicable. (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	08/15/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a review of Resident 5’s face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including an unstageable pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of the sacrum region, type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 5’s Minimum Data Set (MDS- a resident assessment tool), dated 7/9/2025, the MDS indicated Resident 5’s cognitive skills were severely impaired. The MDS also indicated Resident 5 was dependent on staff with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview, on 8/14/2025, at 9:21 a.m., with Treatment Nurse 1 (TN 1), TN 1 was observed disinfecting Resident 5’s bedside table with Sani-cloth alcohol wipes without wearing gloves. TN 1 performed hand hygiene and began prepping Resident 5’s pressure ulcer medication and supplies without wearing gloves. TN 1 stated gloves should be worn when disinfecting bedside equipment and while preparing supplies for a resident with a pressure ulcer. TN 1 stated she did not wear gloves when she disinfected the bedside table and prepped supplies. TN 1 stated the risk of not wearing gloves while disinfecting the bedside table and prepping pressure ulcer medication and supplies could result in transferring bacteria to Resident 5’s wound, causing an infection. During a review of the facility’s policy and procedures (P&P), titled “Personal Protective Equipment- Using Gloves”, undated, the P&P indicated, “ Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient and when cleaning contaminated surfaces.”