STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056499	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Little CO of Mary Transitional Care Ctr	4320 Maricopa Street 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 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 implement the discharge plan to ensure a safe discharge for one of three residents (Resident 1) by not providing the resident with a written discharge notice 30 days prior to discharge.This deficient practice placed Resident 1 at risk for an unsafe discharge.During a review of Resident 1's History and Physical (H&P), dated 9/26/2025, the H&P indicated the facility admitted Resident 1 on 9/25/2025 for rehab with diagnoses that included failure to thrive (a syndrome characterized by a rapid decline in physical, functional, and cognitive abilities), right renal mass (an abnormal growth in the kidney), and chronic diastolic congestive heart failure (when the left ventricle becomes stiff and cannot relax to fill with enough blood, leading to high pressure and fluid buildup). The H&P indicated Patient 1's neurologic status was alert and oriented times three (awake and aware of who they were, where they were, and what time or date it was), with normal strength, sensation and reflexes throughout, and adequate insight and judgement.During a review of Resident 1's Hospital Medicine Progress Note, dated 2/9/2026, the Progress Note indicated that Resident 1's admission had been markedly prolonged due to profound debility (a serious and lasting state of physical weakness and loss of strength), need for 24/7 assistance, and inability to safely discharge home, requiring ongoing transitional care. The Progress Note further indicated that care had focused on nutritional optimization, pressure injury management, and intensive PT/OT (physical therapy/occupational therapy - physical therapy: exerciseˆbased treatment to improve strength, movement, and mobility; occupational therapy: therapy that helps people relearn everyday activities and adapt environments to support selfˆcare and daily living) with slow but measurable functional gains, and that case management remained involved for long-term placement planning.During a review of Resident 1's Interdisciplinary Team Care (IDT - a collaborative documentation entry created by a team including nurses, providers, case management [healthcare professionals who assess the patient's needs, develop and coordinate a personalized plan of care, facilitate access to services like placement and community resources, advocate for the patient, monitor progress, and support smooth transitions across care settings], and physical therapy to review, update, and plan care for complex patients, particularly in hospice, palliative, or long-term care settings) Conference Note, dated 2/19/2026, the Conference Note indicated that Resident 1 was 100% incontinent in both bowel and bladder (unable to control bladder or bowel functions) and unable to perform toileting. The Conference Note further indicated Resident 1 needed maximum assistance with feeding, grooming, dressing, bathing, and transferring from bed to chair.During a review of Resident 1's Social Worker Note, dated 2/19/2026, the Social Worker Note indicated case management e-mailed Resident 1?s responsible party (RP 1) and proposed a discharge date of 2/26/2026 to RP 1's home with home health. The Social Worker Note indicated RP 1 sent an e-mail to case management that expressed RP 1 did not appreciate the discharge date being pushed onto RP 1 and stated that a 30 days' notice of discharge needed to be presented to Patient 1 and/or Patient 1's family. The Social Worker Note further indicated that case management updated leadership.During a review of Resident 1's Hospital Medicine Discharge summary, dated [DATE], the Discharge Summary (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Providence Little CO of Mary Transitional Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 Maricopa Street Torrance, CA 90503	

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 1 was discharged from the facility on 2/21/2026.During an interview on 3/5/2025 at 12:52 p.m. with RP 1, RP 1 stated the facility did not provide the 30-day written discharge notice prior to the discharge.During an interview on 3/5/2025 at 11:58 p.m. with Social Worker (SW) 1, SW 1 stated that there was no written notice provided to Resident 1 or RP 1 and SW 1 did not know if they were required to provide a 30-day written notice to patients prior to the discharge.During an interview on 3/5/2025 at 2:00 p.m. with the Director of Nursing (DON), the DON stated they did not provide the 30-day written notice to Resident 1 or Resident 1's family. DON 1 stated that the facility's policy did not mention the 30-day discharge written notice. DON further stated they were not aware of this regulation and they would revise the policy per regulation and provide training to staff.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure the care plan was updated for one of three sampled residents (Residentˆ1) who demonstrated the behavior of uncovering self, which was necessary to maintain Residentˆ1's dignity and rights.This deficient practice resulted in Residentˆ1 not receiving specific interventions to address the uncovering behavior, leading to exposure of private areas and a failure to maintain Residentˆ1's dignity and rights.During a review of Resident 1's History and Physical (H&P), dated 9/26/2025, the H&P indicated the facility admitted Resident 1 on 9/25/2025 for rehab with diagnoses that included failure to thrive (a syndrome characterized by a rapid decline in physical, functional, and cognitive abilities), right renal mass (an abnormal growth in the kidney), and chronic diastolic congestive heart failure (when the left ventricle becomes stiff and cannot relax to fill with enough blood, leading to high pressure and fluid buildup). The H&P indicated Patient 1's neurologic status was alert and oriented times three (awake and aware of who they were, where they were, and what time or date it was), with normal strength, sensation and reflexes throughout, and adequate insight and judgement.During a review of Resident 1's Hospital Medicine Progress Note, dated 2/9/2026, the Progress Note indicated that Resident 1's admission had been markedly prolonged due to profound debility (a serious and lasting state of physical weakness and loss of strength), need for 24/7 assistance, and inability to safely discharge home, requiring ongoing transitional care. The Progress Note further indicated that care had focused on nutritional optimization, pressure injury management, and intensive PT/OT (physical therapy/occupational therapy - physical therapy: exerciseˆbased treatment to improve strength, movement, and mobility; occupational therapy: therapy that helps people relearn everyday activities and adapt environments to support selfˆcare and daily living) with slow but measurable functional gains, and that case management remained involved for long-term placement planning.During a review of Resident 1's Interdisciplinary Team Care (IDT - a collaborative documentation entry created by a team including nurses, providers, case management [healthcare professionals who assess the patient's needs, develop and coordinate a personalized plan of care, facilitate access to services like placement and community resources, advocate for the patient, monitor progress, and support smooth transitions across care settings], and physical therapy to review, update, and plan care for complex patients, particularly in hospice, palliative, or long-term care settings) Conference Note, dated 2/19/2026, the Conference Note indicated that Resident 1 was 100% incontinent in both bowel and bladder (unable to control bladder or bowel functions) and unable to perform toileting. The Conference Note further indicated Resident 1 needed maximum assistance with feeding, grooming, dressing, bathing, and transferring from bed to chair.During an interview on 3/5/2025 at 12:05 p.m. with the Assistant Nurse Manager (ANM), ANM stated that staff observed Resident 1 tended to uncover themselves sometimes. ANM stated that staff should have interventions for this behavior and update Resident 1's care plan to maintain resident dignity.During an interview on 3/5/2025 at 12:52 p.m. with Resident 1's responsible party (RP 1), RP 1 stated she observed Resident 1's private area from the waist down to the lower extremities was exposed to the public when she was outside Resident 1's room in the hallway. RP 1 stated that she talked to the staff and the staff informed RP 1 that the facility was a diaper-free clinic to prevent residents having skin and infection problems.During a communication email with the Regulatory Accreditation Program Manager (RARM), dated 3/9/2026, RARM indicated that no intervention or care plan was found regarding Resident 1's tendency to uncover himself during Resident 1's admission to the facility.During a review of Resident 1's care plan audit trail (a record that tracks all updates made to the care plan, including who made the changes and when) from 10/28/2025 to 2/21/2026, the audit trail indicated there was no care plan updated regarding Resident 1's behavior of uncovering self.During a review of the facility's policy and procedure (P&P) titled, TCC/TCU: Minimum Data Set [MDS] and Care Planning, last approved 3/2025, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, The Care Plans will be initiated within 24 hours of admission. It is reviewed and updated on specified times/dates, and as needed whenever there is a new order or change of intervention, and when interventions become ineffective or not applicable; it is discontinued when a problem is resolved or when a patient is discharged .