

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Palos Verdes Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 26303 Western Ave. Lomita, CA 90717	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to provide sufficient dietetic (concerning diet and nutrition) oversight for 46 out of 46 sampled residents. The Dietary Supervisor was not working full-time, and the Registered Dietitian was functioning only on a consulting basis. This lack of oversight was evidenced by lapses in food service delivery, including kitchen staff not following the scheduled menu for pureed diets, inaccuracies in therapeutic diets, inadequate maintenance of essential kitchen equipment such as the ice machine and dishwashing machine, and deficiencies in food safety and sanitation practices. These failures had the potential to compromise residents' safety and nutritional status through possible transmission of foodborne illness, incorrect delivery of physician-ordered therapeutic diets, and increased risk of aspiration (accidental breathing food, liquid, or saliva into the airway and lungs instead of swallowing into the esophagus and stomach) due to improper food texture. Findings: During the annual recertification survey from 2/9/2026 to 2/12/2026, multiple issues surrounding the delivery of dietetic services were not met in relation to: 1. The oversight of food safety, sanitation, and storage of food in the kitchen (Cross reference F 812). 2. Ice machine not clean and sanitary (Cross reference F 908 and F 812). 3. Dish washing machine was not reaching the correct temperature for a low temperature dishwasher (Cross reference F 812). 4. [NAME] 1 failed to follow scheduled and planned menu for Resident 16 and 41 diets (Cross reference F 803). 5. Dietary Aide failed to ensure the coconut cake distributed during tray line for two residents (Resident 16 and 41) had the correct texture according to their therapeutic diets (cross reference F 803). During an interview on 2/9/2026 at 11:45 a.m., the Dietary Supervisor (DS) stated he worked only on weekends and was serving as a part-time Dietary Supervisor in the facility. He stated the last full-time Dietary Supervisor resigned on 1/28/2026. During review of DS's Time Detail Report (work hour log) dated 1/31/2026 (Saturday) to 2/6/2026 (Friday), the Time Detail Report indicated the DS worked for 15 hours for a week. During an interview on 2/11/2026 at 2:54 p.m. with the Administrator (ADM), the ADM stated the DS only worked part time and only during the weekends. The ADM stated there was a dietary supervisor last January 2026 but he only lasted for two weeks. The ADM stated there was a contracted registered dietician and would come once a week in the facility. The ADM stated the facility did not place an advertisement to hire a full-time DS and rely only on using word by mouth (passing of information, news, recommendations from a person to person through spoken, oral communication). The ADM stated it was important to have a full-time Dietary Supervisor in the kitchen to oversee operations and ensure that regulatory requirements were followed. During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietician (RD), RD stated the kitchen should have a full-time DS to provide an oversight and to ensure the kitchen follows the food and safety regulations. During a review of facility's Job Description of Food and Nutrition Services (FNS) Director dated 2018, the Job Description of FNS Director indicated the supervisor will confer regularly with the Administrator, Director of Nursing, and Dietary Consultant and keep them informed of the problems and progress of Food and Nutrition Service Department. Cross Reference F803, F812 and F908.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555028
		If continuation sheet Page 1 of 25

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the trash receptacle outside the kitchen was covered, not overflowing, and properly disposed of. This failure had the potential to attract pests and rodents, pose health risks, and result in infection control violations. Findings: During a concurrent observation and interview on 2/09/2026 at 8:40 a.m. with [NAME] 1, the garbage dumpster outside the kitchen was observed to be completely open, with black trash bags overflowing from it. [NAME] 1 stated that this was the kitchen's garbage dumpster. During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietitian (RD), the RD stated garbage dumpsters must be kept completely closed. The RD stated an open and overflowing dumpster could attract insects and rodents, potentially leading to infestation. During an interview on 2/12/2026 at 1:13 p.m. with the Director of Nursing (DON), the DON stated the garbage dumpster should not be overflowing with trash and must remain covered. The DON stated improper disposal of trash could attract unwanted pests and insects.		

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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. Based on observation, interview, and record review, the facility failed to 1. Ensure that the water temperature reached the required 160 degrees Fahrenheit (F- unit of temperature) for proper sanitation when washing residents' laundry in two of three facility washing machines. This failure had the potential to cause cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products), exposing residents' laundry to bacteria, viruses, and other harmful microorganisms due to inadequate sanitization. 2. Review and update facility's policies and procedure for Infection Prevention and Control Program (IPCP- structured, evidence-based plan used in the facility to stop the spread of germs and protect residents and staff) annually. This failure had the potential to not address current infection trends leading to higher rates of infection in the facility. Findings: 1. During an observation on 2/11/2026 at 12:40 p.m. in the laundry room, two washing machines were running. The temperature gauge used to monitor the water temperature was reading 85 degrees F. During a review of the Daily Washer Temperature Log dated 2/1/2026 last revised on 2/11/2026, the Washer Temperature Log indicated the water temperature should be between 140 degrees F to 160 degrees F. The washer temperature log indicated that the water temperature ranged between 85 degrees F to 106 degrees F for the month of February. During an interview on 2/11/2026 at 12:45 p.m. with the Laundry Aide, Laundry Aide stated she checks the thermometer when the washer begins its cycle and then records the temperature on the log. The Laundry Aide stated the Laundry Supervisor instructed her only to record the temperature and did not tell her to report if the temperature failed to reach 140 degrees F to 160 degrees F. She stated when clothes were not sanitized properly, there was a risk of spreading germs (organisms that can cause disease) to the residents. During a concurrent observation and interview on 2/12/2026 at 12:10 p.m. with the Maintenance Supervisor (MS) in the laundry room, the MS used a hand-held thermometer to manually check the water temperature of a running washing machine. The MS stated the water temperature was only 80 degrees F and that he would need to adjust the water heater. The MS stated the water temperature must reach 160 degrees F to kill germs and that there was a possibility of cross-contamination when the temperature does not reach 160 degrees F. During a review of the facility's policy and procedure (P&P) titled Washer Temperature, (undated) the P&P indicated Nursing homes must follow strict laundry protocols to prevent infection, including proper sorting, handling, washing, and storage of linens, in compliance with Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), and Centers for Medicare and Medicaid Services (CMS) guidelines. 1. Infection Control and Handling: Laundry in nursing homes can carry pathogens from blood, urine, stool, and other body fluids. To minimize risk, soiled linens must be handled carefully: avoid shaking, use leak-proof bags or carts, and transport separately from clean linens to prevent cross-contamination. Staff should wear personal protective equipment (PPE) such as gloves, gowns, and masks when handling contaminated laundry (CDC, OSHA, Western State Design). 2. Sorting and Collection: Linens should be sorted into categories such as infectious, non-infectious, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and heavily soiled. Staff must be trained to segregate items properly, and containers should be labeled with biohazard symbols when necessary (OSHA). Contaminated laundry should never be transported through common areas without containment. 3. Washing and Disinfection: CMS and CDC guidance recommend hot water washing at temperatures above 160 degrees F (71 degrees C) for at least 25 minutes. 2. During a concurrent interview and record review on 2/12/2026 at 10:34 a.m. with the Infection Preventionist Nurse (IPN), facility's policy for Infection Prevention and Control Program revised on 6/8/2022 was reviewed. IPN stated he did not know the policy for IPCP needed to be reviewed annually and update as needed. IPN stated it was the responsibility of the Director of Nursing (DON) to review the policy for IPCP. IPN stated reviewing the policy can help prevent transmission of diseases in the facility. During a concurrent interview and record review with the DON on 2/12/2026 at 12:57 p.m., the facility's IPCP policy was reviewed. The DON stated the Infection Prevention and Control Program policies were last reviewed in 2022. The DON stated the IPN, Medical Records Department, and the DON were responsible for reviewing the facility's policies. The DON stated failing to review and update the IPCP policies may result in the facility providing care that was not aligned with current infection prevention and control standards During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised 6/8/2022, the P&P indicated the facility will review its IPCP at least annually and update as needed.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure four of 44 sampled residents (Resident 2, Resident 32, Resident 16 and Resident 41) received meals according to the scheduled dietary menu and prescribed diet textures. The facility failed to: 1. Ensure Resident 2 and 32 were provided with a pureed fortified meal as scheduled on the facility's dietary menu. 2. Ensure Resident 16 and Resident 41 receive the correct texture and consistency of coconut cake during tray line on 2/10/2026 according to their prescribed diet. These failures had the potential to put Resident 2, Resident 32, Resident 16 at risk for not meeting their nutritional needs and Resident 41 at risk for aspiration (accidental breathing of food, fluids, or stomach contents into the airway and lungs instead of the esophagus). Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of but not limited to seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak), and hypertension (HTN-high blood pressure) During a review of Resident 2's Physician Progress Note, dated 11/22/2025 the Physician Progress Note indicated Resident 2 does not have the capacity to understand and make decisions. The Physician Progress Note indicated Resident 2 was at risk for but limited to malnutrition (health problems that may arise due to lack of nutrients), weight variance, and dehydration (abnormally low fluid levels in the body). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 2 needed partial to moderate assistance with eating and rolling from left to right. The MDS indicated Resident 2 needed substantial to maximal assistance with oral hygiene, toileting, dressing and personal hygiene. The MDS indicated Resident 2 was dependent on nursing staff with showering, putting on and taking off shoes, and transferring. The MDS indicated Resident 2 received a mechanically altered diet that required a change in texture of food or liquids. The MDS indicated Resident 2 was provided with a therapeutic diet while a resident at the facility. During an interview on 2/9/2026 at 12:51 p.m., with Dietary Aide, (DA) 1 stated Resident 2 and Resident 32 were served a pureed diet (foods that are blended, whipped, or mashed into a smooth, thick, pudding-like consistency, requiring no chewing) mixed vegetables, pureed rice and pureed Salisbury steak. During a review of the facility's menu dated 2/9/2026, the facility's menu indicated the lunch meal to be served was pork chops with gravy, herbed rice, mixed vegetables, dinner roll with margarine, coconut cake and a beverage. During an interview on 2/9/2026 at 1:52 p.m. with [NAME] (CK) 1, CK 1 stated there were three slices of Salisbury steak stored in a clear bag in the refrigerator. CK 1 stated she made a mistake and apologized for deciding on her own to serve the Salisbury steak. CK 1 stated she was supposed to serve pork chops as listed on the menu. CK 1 stated the residents would not be happy if they did not receive the food items listed on the menu. CK 1 stated residents expect to receive what was scheduled, and some may refuse to eat if the served meal does not match the posted menu. CK 1 (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that even residents who are not alert are supposed to receive the same food that was on the menu. During an interview on 2/12/2026 at 3:12 p.m. with the Director of Nursing (DON), the DON stated that [NAME] 1 should have followed the recommended menu. The DON stated residents could end up in the hospital or experience an upset stomach if the recommended menu was not followed. During a review of the facility's Policy and Procedure (P&P), titled Menus, dated 10/2027, the P&P indicated .Deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived. 2.During a tray line observation on 2/10/2026 at 12:00 p.m., Resident 41 received coconut cake in a regular texture (normal diet with no restrictions on the size, shape, or hardness of food) and Resident 16 received coconut cake in a mince and moist texture (finely chopped, ground, or mashed into small, soft and uniform pieces). Resident 41's meal tray ticket indicated a diet of mechanical soft diet (consists of moist, tender-textured foods that require minimal chewing which is ideal for individuals with chewing or swallowing difficulties) and Resident 16's meal tray ticket indicated pureed diet(consist of foods that are blended, mashed, or whipped until they reach a completely smooth, pudding like consistency with no lumps, seeds or chunks). During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia(difficulty in swallowing), and colostomy status(a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body). During a review of Resident 16's History and Physical (H&P) dated 2/1/2026, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's Order Summary Report dated 2/11/2026, the Order Summary Report indicated a physician order of controlled carbohydrate (CCHO- meal plan that involves a steady amount of carbohydrates at each meal and snack to help manage blood sugar levels) mechanical soft texture with nectar / mildly thick consistency diet(moist, tender finely diced or ground foods combined with beverages thick enough to pour slowly to aid with swallowing). During a review of Resident 16's Care Plan titled, Alteration in Nutrition due to Current Diet Order, initiated 12/24/2025 and revised on 1/10/2026, the Care Plan goal indicated Resident 16 will have no significant weight loss or gain within thirty days. The Care Plan interventions included providing CCHO Soft Mechanical with nectar thick liquid and provide diet as ordered. During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was admitted on [DATE] to the facility with diagnoses including dysphagia, DM, unspecified dementia (a progressive state of decline in mental abilities), and benign neoplasm of meninges (a non-cancerous tumor that grows on the protective membranes surrounding the brain and spinal cord). During a review of Resident 41's H&P dated 5/1/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Order Summary Report dated 5/13/2025, the Order Summary Report (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated a physician order of Regular diet with mechanical soft texture. During a review of Resident 41's Care Plan titled, Nutrition and Hydration Deficit, initiated 5/13/2025 and revised on 5/21/2025, the Care Plan goal indicated Resident 41 will consume 80 percent of each meal. The Care Plan interventions included providing diet as ordered and adhering to resident's food preferences by dietary department within diet order. During an interview on 2/10/2026 at 2:09 p.m. with Dietary Aide (DA) 1, DA 1 stated one of his responsibilities was to place dessert and drinks during tray line. DA 1 stated he was confused and placed the coconut cake with mince and moist consistency who was on pureed diet and placed a regular consistency coconut cake to Resident 41 who was on mechanical soft diet. DA 1 stated he should have checked each dessert or removed the lid before setting them on the residents' trays, DA 1 stated residents had the potential to choke or aspirate their food if the wrong texture of food was provided. During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietician (RD), RD stated inaccurate therapeutic diets, incorrect food texture can run the risk of aspiration to residents. RD stated the kitchen staff should follow the menu because it was reviewed and approved by the RD to ensure residents' nutritional needs were met. During a review of facility's policy and procedure (P&P) titled, Diet Orders, dated 2018, the P&P indicated Diet orders as prescribed by the physician will be provided by the Food and Nutrition Services Department. The P&P indicated the Dietary Supervisor or [NAME] will make or adjust the diet profile and tray card as prescribed.		

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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 store food in a safe and sanitary manner for 44 out of 46 sampled residents in the facility. The facility failed to: 1. Ensure reach in refrigerator had an internal thermometer that was in working condition. 2. Ensure dish washing machine was maintained and operated at the proper recommended temperature of 120 degrees Fahrenheit (F- unit of measurement). 3. Ensure the ice machine was clean and sanitary. 4. Ensure [NAME] (CK) 2 washed her hands after touching the lid of a step on trash can before stirring the soup in the stove. 5. Ensure an open brown bag of flour and an open bag of pasta were stored in a sanitary manner in the dry storage area. These failure had the potential to cause cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products), infestation (presence of an unusually large number of insects or animals in a place that can cause damage or disease) and put residents at risk for developing food-borne illnesses (any illness resulting from eating contaminated/spoiled foods). Findings: 1. During an initial kitchen observation and interview on 2/9/2026 at 8:20 a.m. with [NAME] (CK) 1, observed reach in refrigerator had no internal thermometer but external digital display read 39 F. Observed the internal thermometer was cracked and reading remained 30 F despite being left out in the kitchen counter for several minutes. CK 1 stated the thermometer was broken. During an interview on 2/9/2026 at 12:15 p.m. with the Dietary Supervisor (DS), the DS stated the kitchen staff used only the external digital display of temperature of refrigerators and freezer. DS stated the internal thermometer of the refrigerator was broken and he will buy a new thermometer. During a subsequent interview on 2/9/2026 at 1:50 p.m. with CK 1, CK 1 stated the kitchen staff had been relying and using the external digital temperature displayed on the freezer and refrigerators for three years and had never used the internal thermometer inside the freezer and refrigerators for temperature check. CK 1 stated she never checked the internal thermometer and only relied on the temperature reading displayed outside of the refrigerator. CK 1 stated it was important to check the internal thermometer to ensure the food items stored are in the correct and right temperature to prevent food-borne illnesses among the residents. During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietician (RD), the RD stated not having an internal thermometer inside a refrigerator was not standard practice. RD stated broken thermometer should be replaced and the external temperature should not be followed because in case the digital thermometer breaks down there will be a second thermometer to rely on ensuring safety of the food items stored in the refrigerator. RD stated food spoilage can happen if the kitchen was only relying on the external digital thermometer leading to food-borne illness among the residents. During an interview on 2/12/2026 at 1:13 p.m. with the Director of Nursing (DON), the DON stated internal thermometer was important to use for refrigerator to ensure a reliable way to check the temperature and prevent food spoilage which can lead to food-borne illnesses. During a review of facility's policy and procedure (P&P) titled, Food Storage, dated 2010, the P&P indicated every refrigerator should be equipped with an internal thermometer. 2. During a concurrent observation and interview on 2/9/2026 at 8:50 a.m., with the Dietary Aide (DA) 2, DA 2 ran the dish washing machine and temperature gauge read 104 F. DA 2 stated it was okay to still use the dishwasher even though the temperature gauge was not reaching 120 F as long as the chemical sanitation (using test strips to check the level of sanitizer during the final rinse of the dish washer) was within the range of 50 to 100 parts per million (PPM- a way to measure very small amounts of substance like a sanitizer). During an observation and interview 2/9/2026 at 11:45 a.m., with the Dietary Supervisor (DS), DS stated the dish washer should read 120 F to properly sanitize and kill the bacteria present on the dishes and utensils. Observed DA 2 ran the dishwasher five times and the temperature gauge did not reach 120 F. Observed the temperature gauge read 110 F after five cycles were run. DS stated he did not know the dishwasher (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not working till today (2/9/2026) at 10:30 a.m. and would call a service provider. DA 1 stated residents could get sick of food-borne illnesses if the temperature gauge of the dish washing machine was not 120 F. DS stated they will use disposable utensils and food containers/ plates for today's lunch (2/9/2026).During a subsequent observation on 2/9/2026 at 2:29 p.m., dishwashing machine temperature gauge read 102 F when DA 2 ran a cycle.During an interview on 2/9/2026 at 2:47 p.m. with the Administrator (ADM), the ADM stated the DS notified him around 11:00 a.m. today (2/9/2026) about the dish washer not reaching the required temperature and he would call a service provider to check the dishwashing machine.During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietician (RD), the RD stated the dishwasher not reaching the recommended temperature of 120 F should be reported and addressed to ensure dishes will be cleaned properly and to prevent food-borne illnesses among residents.During a review of facility's P&P titled, Dishwashing Machine Use, revised 3/2010, the P&P indicated, the operator of the dish washing machine will check the temperature using the machine gauge with each dishwashing machine cycle and inadequate temperatures should be reported to the supervisor and corrected immediately. The P&P indicated if hot water does not meet requirements, stop the use of dishwashing immediately until the temperature is adjusted.3. During an observation in the kitchen on 2/9/2026 at 9:45 a.m. with Dietary Aide (DA) 2, yellow residue was found in the paper towel that was used to wipe the lid of the ice machine. Observed dirt and black areas inside the ice machine.During an interview on 2/9/2026 at 2:10 p.m. with DA 2, DA 2 stated the ice machine was dirty if there was a yellow residue on the paper towel after wiping the inside of the ice machine. DA 2 stated the ice machine was serviced and cleaned by a service provider two months ago. DA 2 stated he cleaned the ice machine 2 or 3 days ago and an outside company will take the machine apart and clean it. DA 2 stated residents can be exposed to food -borne illnesses if the ice machine was not clean and sanitary.During an interview on 2/12/2026 at 9:45 a.m. with the Maintenance Supervisor (MS), the MS stated he removed the ice and cleaned the interior and exterior of ice machine yesterday by wiping it with clean towels. MS stated the ice machine should be taken apart and serviced by a technician to completely clean it.During an interview on 2/12/2026 at 9:50 a.m. with the Administrator (ADM), the ADM stated the ice machine was serviced and cleaned last September 2025 and the facility will throw away all the ice and will not be used for the residents. The ADM stated the facility will buy ice for residents' use. ADM stated the ice machine will be checked and cleaned by an outside provider today.During an interview on 2/11/2026 at 3:50 p.m. with the RD, RD stated the ice machine should be clean and sanitary. RD stated the ice machine should be clean and sanitized by the maintenance department and kitchen staff should be able to clean exterior portion of the ice machine. RD stated there should be someone in the facility responsible for sanitizing and cleaning it periodically or once a month. RD not cleaning or sanitizing the ice machine can lead to food-borne illnesses among residents.During an interview on 2/12/2026 at 11:09 p.m. with Infection Preventionist Nurse (IPN), IPN stated dirty and unsanitary ice machine can place residents at risk for legionella infection (type of bacteria found in water that causes serious lung infection).During a review of facility's P&P titled Ice Machine Cleaning Procedures, dated 2018, the P&P indicated the ice machine needs to be cleaned monthly.4. During an observation on 2/10/26 at 11:50 a.m. with CK 2, CK 2 threw a spoon in a step on trash can by lifting its lid and proceeded to stir a pot in the stove without doing handwashing.During an interview on 2/10/2026 at 12:45 p.m. with CK 2, CK 2 admitted that she threw a spoon in the trash can by lifting the lid of the step on trash can and then went back to stir the soup in the stove without doing handwashing.CK 2 stated she should have washed her hands after touching the lid of the trash can and should be careful in observing infection control measures. CK 2 stated resident can get sick from food-borne illnesses and can be a risk for cross contamination if hand washing was not performed after touching the lid of the trash can.During an interview on 2/12/2026 at 1:13 p.m. with the DON, the DON stated cross contamination leading to food-borne illnesses would occur if CK 2 did not wash her hands after touching the lid of the trash can to throw a spoon. The DON stated CK 2 should have washed her hands before touching the ladle to (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stir the soup.During a review of facility's P&P titled Handwashing Procedure, dated 2018, the P&P indicated hands should be washed after touching the lid or the trash can to prevent spread of infection.5.During an initial kitchen tour observation and interview on 2/9/2026 at 8:20 a.m. with CK 1 in the dry storage area of the kitchen, open brown bag of flour and open unsealed bag of pasta were found on one of the shelves. CK 1 stated the open bag of flour should have been transferred into a sealed plastic bin to ensure freshness and prevent insects going into the open bag of flour.During an interview on 2/9/2026 at 1:50 p.m. with CK 1, CK 1 stated the open bag of pasta should have been stored in a sealed plastic bag and the open bag of flour should be in a plastic, tight sealed container to ensure their freshness and keep the pest away from the food.During an interview on 2/11/2026 at 3:50 p.m. with the RD, RD stated the flour should be stored in a plastic bin or sealed plastic bag to keep food debris or other organisms from going into them which can put residents at risk for food-borne illnesses.During a review of facility's P&P titled Food Storage, dated 2018, the P&P indicated Dry storage area should have plastic containers with tight-fitting lids used for storing flour, cereals, and sugar. The P&P indicated leftover food is stored in covered containers or wrapped carefully and securely.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure:1. Two of five residents (Resident 4 and Resident 6) were provided education regarding the risks and benefits of refusing influenza (flu - a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs) and pneumococcal (pneumonia - an infection/inflammation in the lungs) vaccines (medications used to prevent diseases).2. One of five residents (Resident 19) was not given the influenza and pneumococcal vaccine.This failure had the potential to result in residents from making informed decisions regarding refusal of influenza and pneumococcal vaccine, increasing the risk for vaccine-preventable illness, complications, hospitalization, and transmission of infection within the facility.Findings:1.a. During a review of Resident 4's Face Sheet (admission Record), the Face Sheet indicated the facility originally admitted Resident 4 on 9/14/2024 and was re-admitted on [DATE] with diagnoses including frontal lobe (part of the four major lobes in the human brain) and executive function deficit following cerebral infarction (blocked blood flow to the brain resulting in tissue death)During a review of Resident 4's history and physical (H&P) dated 11/12/2025, the H&P indicated Resident 4 does not have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/16/2025, the MDS indicated Resident 4 cognition (ability to think and make decisions) was severely impaired.During a review of Resident 4's care plan titled Risk for adverse reaction or discomfort related to Covid and flu immunization received on 10/3/2025 dated 9/16/2025, the care plan indicated to educate the resident and responsible party on the purpose of the Covid and flu vaccine, possible side effects, and the importance of vaccination in preventing Covid and influenza disease.During a concurrent interview and record review on 2/11/2026 at 1:30 p.m. with the Licensed Vocational Nurse (LVN)1 Resident 4's immunization screening was reviewed. Resident 4 immunization record indicated influenza vaccination was given on 10/3/2025 and the vaccination informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was received over the phone by the responsible party. LVN 1 stated there was no documentation the resident's responsible party was given education for the vaccine. LVN 1 stated the importance of providing education to the resident and the responsible party was to explain the risks of not receiving the vaccine and benefits of receiving the vaccine.During a concurrent interview and record review on 2/11/2026 at 2:50 p.m. with the Infection Preventionist Nurse (IPN), Resident 4's immunization screening was reviewed. The IPN stated vaccination education was not given. The IPN stated the resident's responsible party should have been educated for the influenza vaccine. The IPN stated the importance of providing education was to explain the risk and benefits of the vaccine.1.b. During a review of Resident 6's Face Sheet (admission Record), the Face Sheet indicated the facility admitted Resident 6 on 1/17/2026 with diagnoses including end stage renal disease (ESRD -irreversible kidney failure)During a review of Resident 6's history and physical (H&P) dated 11/17/2026, the H&P indicated Resident 6 had capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 1/23/2026, the MDS indicated Resident 6 cognition was moderately impaired. The MDS indicated Resident 6 did not receive influenza for the flu season of October 1, 2025 - March 31, 2026, and the pneumococcal vaccination. The MDS indicated the influenza, and pneumococcal vaccine was offered and was refused.During a review of Resident 6 physician orders, dated 1/17/2026, the physician's order indicated to administer flu vaccine 0.5 cc (cubic centimeters, unit of volume), intramuscular (IM), give one time as consent obtained. The physician's order indicated the resident may have annual influenza vaccine and pneumococcal vaccine.During a concurrent interview and record review on 2/11/2026 at 1:30 p.m. with the Licensed Vocational Nurse (LVN) 1, Resident 6's immunization screening was reviewed. Resident 6 immunization record showed the last influenza vaccine was given on 11/2022. (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 1 stated there were no informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) or documentation the resident was given education for both vaccines. LVN 1 stated the importance of providing education to the resident was to explain the risks of not receiving the vaccine and benefits of receiving the vaccine. LVN 1 stated if the resident does not receive immunizations, the resident would be at an increased risk of exposure to the flu and pneumonia virus and development of other virus-related complications. During a concurrent interview and record review on 2/11/2026 at 2:50 p.m. with the Infection Preventionist Nurse (IPN), Resident 6's immunization screening was reviewed. The IPN stated vaccination education was not offered or given. The IPN stated the flu season was from October 1st to March 31st and the resident should have been educated and offered the influenza vaccine. The IPN stated an informed consent should have been obtained on admission for influenza and pneumonia but there was no informed consent obtained. The IPN stated the importance of providing education was so that the resident was informed that there could be an increased risk of exposure to the virus and development of other virus-related complications. During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Influenza and Pneumococcal immunizations revised 6/8/2022, indicated Influenza immunization will be offered to current residents and newly admitted residents annually during the flu season. The resident/resident representative will be provided information related to the risks of potential side effects and benefits of being immunized prior to the resident receiving the vaccination. This will be accomplished via the Vaccination Information Sheet from the CVC. The resident record will reflect the provision of education and the administration or refusal of the immunization, or non-administration due to the medical contraindication, precaution or other reason for non-administration of the vaccine. Residents >[AGE] years of age and those age [AGE]-64 with chronic medical conditions or other risk factors, who have not previously received pneumococcal vaccine, or whose previous vaccination history is unknown are offered pneumococcal vaccination. 2. During a review of Resident 19's Face Sheet (admission Record), the Face Sheet indicated the facility admitted Resident 19 on 1/26 /2026 with diagnoses including syncope (fainting or passing out). During a review of Resident 19's history and physical (H&P) dated 1/26/2026, the H&P indicated Resident 19 had partial capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool) dated 1/30/2026, the MDS indicated Resident 6 did not receive the influenza vaccine and the reason was the vaccine was offered and declined. MDS indicated the resident's pneumococcal vaccine was not up to date and was offered and declined. During a review of Resident 19's physician orders, dated 1/26/2026 indicated the resident was capable of giving informed consent. The physician's order indicated to administer flu vaccine 0.5 cc (cubic centimeters, unit of volume), intramuscular (IM), give one time as consent obtained. The physician's order indicated may have annual influenza vaccine and pneumococcal vaccine. During a concurrent interview and record review on 2/11/2026 at 1:30 p.m. with the Licensed Vocational Nurse (LVN) 1 Resident 19's immunization screening was reviewed. Resident 19 immunization record showed no documentation for immunizations. LVN 1 stated there was no documentation of the vaccine being administered on the medication administration record (MAR) for Resident 19. LVN 1 stated the importance of giving the vaccine was for residents to increase their immune system when in contact with the virus. LVN 1 stated when the vaccine was not provided, the resident would be at an increased risk of exposure to the flu and pneumonia virus and development of other virus-related complications. During a concurrent interview and record review on 2/12/2026 at 9:00 a.m. with the Infection Preventionist Nurse (IPN), Resident 19's immunization screening was reviewed. The IPN stated the licensed nurse was responsible for offering the vaccine upon admission to the facility. The IPN stated there was a vaccination informed consent in the resident's physical chart signed and dated on 1/27/2026 by a Registered Nurse (RN). The IPN stated the importance of giving the vaccine was to prevent the risk for vaccine-preventable illness. The IPN stated if the resident does not receive the vaccine there (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would be an increased risk of exposure to the virus and development of other virus-related complications. During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Influenza and Pneumococcal immunizations revised 6/8/2022, indicated Influenza immunization will be offered to current residents and newly admitted residents annually during the flu season. Flu season typically covers October 1 through March 31 each year. Residents >[AGE] years of age and those age [AGE]-64 with chronic medical conditions or other risk factors, who have not previously received pneumococcal vaccine, or whose previous vaccination history is unknown are offered pneumococcal vaccination.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure facility's dishwashing machine was maintained in a safe and operational condition. The facility failed to: 1. Ensure the dishwashing machine's temperature was running at the recommended temperature of 120 degrees Fahrenheit (F- unit of measurement). This failure had the potential to increase the risk of cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and food-borne illnesses (any illness resulting from eating contaminated/spoiled foods) among the residents. Findings: During a concurrent observation and interview on 2/9/2026 at 8:50 a.m., with the Dietary Aide (DA) 1, DA 1 ran the dish washing machine and temperature gauge read 104 F. DA 1 stated it was okay to still use the dishwasher even though the temperature gauge was not reaching 120 degrees F as long as the chemical sanitation (using test strips to check the level of sanitizer during the final rinse of the dish washer) was within the range of 50 to 100 parts per million (PPM- a way to measure very small amounts of substance like a sanitizer). During an observation and interview on 2/9/2026 at 11:45 a.m., with the Dietary Supervisor (DS), DS stated the dish washer should read 120 F to properly sanitize and kill the bacteria present on the dishes and utensils. Observed DA 1 ran the dishwasher five times and the temperature gauge did not reach 120 F. Observed the temperature gauge read 110 F after five cycles were run. DS stated he did not know the dishwasher was not working till today (2/9/2026) at 10:30 a.m. and would call a service provider. DA 1 stated residents could get sick of food-borne illnesses if the temperature gauge of the dish washing machine was not 120 F. DS stated they will use disposable utensils and food containers/ plates for today's lunch (2/9/2026). During a subsequent observation on 2/9/2026 at 2:29 p.m., dishwashing machine temperature gauge read 102 F when DA 1 ran a cycle. During an interview on 2/9/2026 at 2:47 p.m. with the Administrator (ADM), the ADM stated the DS notified him around 11:00 a.m. today (2/9/2026) about the dish washer not reaching the required temperature and would call a service provider to check the dishwashing machine. During an interview on 2/11/2026 at 3:50 p.m. with the Registered Dietician (RD), RD stated the dishwasher not reaching the recommended temperature of 120 F should be reported and addressed to ensure dishes will be cleaned properly and to prevent food-borne illnesses among residents. During a review of facility's policy and procedure (P&P) titled, Dishwashing Machine Use, revised 3/2010, the P&P indicated, the operator of the dish washing machine will check the temperature using the machine gauge with each dishwashing machine cycle and inadequate temperatures should be reported to the supervisor and corrected immediately. The P&P indicated if hot water does not meet requirements, stop the use of dishwashing immediately until the temperature is adjusted. Cross Reference F812		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor one of four sampled residents' (Resident 38) right to self-determination by not accommodating Resident 38's request to have a shower. This failure had the potential to negatively impact Resident 38's quality of life. Findings: During an interview on 2/10/2026 at 9:59 a.m., Resident 38 stated she wanted a shower, but staff refused to provide one, and she had not received a shower for some time. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Parkinson's disease without dyskinesia (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), unspecified dementia (a progressive state of decline in mental abilities), unsteadiness of feet, and history of falling. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) dated 11/12/2025, the MDS indicated Resident 38 had severely impaired cognitive ability to think, learn, remember, use judgement and make decisions) skills and required partial/moderate assistance (helper does less than half the effort to complete the activity) with bathing/showering, and personal hygiene. During an interview on 2/11/2026 at 1:02 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 38 refused to have a shower and did not have a shower last week, but bed bath was provided to the resident. CNA 1 stated Resident 38 asked for a shower yesterday (2/10/2026) but it was late to be provided to the resident, and it was not Resident 38's shower day. CNA 1 stated Resident 38's schedule for shower were Mondays, Wednesdays and Fridays. CNA 1 stated it was her mistake because she did not notify the charge nurse or the incoming shift CNA about Resident 38 requesting for a shower. CNA 1 stated Resident 38 did not need to wait for her shower day to have a shower because it should be provided to a resident regardless of their shower schedule. CNA 1 stated she should have given Resident 38 a shower when she requested it or notified the next incoming shift CNA or the charge nurse that she wanted to have a shower to ensure Resident 38's request was honored and provided. CNA 1 stated not providing a shower to Resident 38 when she requested for it can violate resident's right to choose because her preference to have shower yesterday was not honored. During an interview on 2/12/2026 at 1:09 p.m. with the Director of Nursing (DON), the DON stated Resident 38 should have been given a shower by CNA 1 regardless of resident's schedule for shower. The DON stated not providing a shower when a resident requested can violate resident's rights and Resident 38 will think that nobody cares about her needs in the facility. During a review of facility's policy and procedure (P&P) titled, Resident Self Determination and Participation, revised 2/2021, the P&P indicated Each resident is allowed to choose activities, and schedule health care that are consistent with his or her interest, values, assessments and plans of care including personal care needs.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure missing personal items belonging to one of one sampled resident (Resident 47), including colored pencils and pens used for activities and a personal bottle of hot sauce, were located or replaced. This failure had the potential to result in Resident 47 experiencing frustration or depressed mood due to the facility not returning or replacing the missing items. Findings: During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), quadriplegia (paralysis from the neck down, including legs, and arms), bed confinement and chronic pain. During a review of Resident 47's Physician Progress Notes, dated 11/22/2025, the Physician Progress Note indicated, Resident 47 had the capacity to understand and make decisions. During a review of Resident 47 Minimum data Set (MDS- a resident assessment tool) dated 11/11/2025, the MDS indicated Resident 47 was dependent on nursing staff for showering and transferring. The MDS indicated Resident 47 needed substantial to maximal assistance from nursing staff with toileting, dressing, and rolling from left to right. During an interview on 2/09/2026 at 10:11 a.m., Resident 47 stated he was missing pens, pencils, and a bottle of hot sauce. Resident 47 reported he had informed Scheduler (SCHED) 1 about the missing items, and SCHED 1 told him last week that she would work on replacing them. Resident 47 stated he previously had mechanical pencils with red lead, and when he returned from his shower, the pens and pencils were gone. Resident 47 stated he originally had two bottles of hot sauce, but now only one remained. During an interview on 2/11/2026 at 12:29 p.m., Certified Nursing Assistant (CNA) 2 stated that Resident 47 had colored pencils and that sometimes his belongings fall onto the floor. During an interview on 2/11/2026 at 2:18 p.m. with Scheduler (SCHED) 1, SCHED 1 stated that last week Resident 47 informed her he was missing pens and pencils. SCHED 1 stated she was working with the activity assistant and was waiting for funds to replace the items. SCHED 1 stated she should have notified the social worker so an investigation could be initiated and the missing items replaced. SCHED 1 stated she instead thought she would purchase pens and pencils for activities and did not document a grievance or inform the social worker. SCHED 1 stated she would replace the missing items today (2/11/2026). SCHED 1 stated missing property would make Resident 47 feel bad if it was not replaced. During an interview on 2/12/2026 at 3:09 p.m. with the Director of Nursing (DON), the DON stated that SCHED 1 was supposed to notify the social worker (SW) regarding missing items. The DON stated that the SW was responsible for interviewing the resident regarding any missing or lost property. The DON stated SCHED 1 should have communicated updates to the resident about the missing items so the resident would not feel ignored. During a review of the facility's policy and procedure (P&P) titled Theft and Loss, date revised 4/2021, the P&P indicated It is the policy of this facility to assure each resident's right to retain and use personal possessions, as space permits, unless those possessions infringe on the rights, health or safety of other patients. This facility will take reasonable preventive measures to prevent loss or damage of resident's possessions. suspected theft or loss will be reported in the following manner, items under \$25.00, loss of theft shall be reported on the Social Services referral form and given to Social Services Staff.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 5) was free of chemical restraints (use of medication to control a patient's behavior or restrict the patient's movement and not required to treat the medical symptom).The facility failed to:1.Ensure Resident 5 was provided with non-pharmacological interventions (intervention that does not primarily use medicine) before administering as needed (prn) psychotropic medication (any drugs that affects the brain activities associated with mental processes and behavior) of Ativan (Lorazepam- medicine used to treat anxiety)2.Ensure psychotropic medication used as a prn for Resident 5 did not exceed 14 days.These failures had the potential to put Resident 5 at risk for adverse consequences (unintended, harmful events attributed to the use of medication) due to unnecessary prolonged use of psychotropic medication affecting Resident 5's quality of life.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (emotion characterized by feelings of tension and worried thoughts), and major depressive disorder(a serious mental health conditions characterized by a persistently low mood, deep sadness).During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 1/15/2026, the MDS indicated the resident had moderately impaired cognition (a person has noticeable difficulties with memory, language, or thinking skills) and required substantial/ maximal assistance (helper does more than half the effort) with bathing, dressing, toileting hygiene and oral hygiene.During a review of Resident 5's History and Physical (H&P) dated 1/11/2026, the H&P indicated Resident 5 had a fluctuating capacity to understand and make decisions and was able to make decisions for daily living activities.During a review of Resident 5's Order Summary Report dated 2/8/2026, the Order Summary Report indicated a physician order of Ativan (Lorazepam) .5 milligram (mg.- unit of measurement) by mouth every six hours as needed for anxiety manifested by restlessness with indefinite duration (no stop date).During a review of Resident 5's Care Plan titled, Resident noted with behavior of anxiety manifested by restlessness and constant yelling, initiated on 2/9/2026, the Care Plan indicated Resident 5 was on lorazepam 0.5 mg. every 6 hours. The Care Plan goal indicated Resident 5 will have less than one episode per week. The Care plan indicated interventions that included administering lorazepam as needed and attempting to refocus behavior to something positive when Resident 5 was exhibiting the behavior.During a concurrent interview and record review on 2/11/2026 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 5's Order Summary Report and Medication Administration Record dated February 2026 were reviewed. LVN 3 stated a physician order of Ativan 0.5 mg. every six hours as needed for anxiety manifested by restlessness dated 2/8/2026 had no stop date and had an indefinite duration. LVN 3 stated there were no non-pharmacological interventions documented in the MAR before administering Ativan prn. LVN 3 stated non-pharmacological interventions should be provided to the resident like repositioning, dimming lights, or providing water before a prn psychotropic medication like Ativan was administered to the resident. LVN 3 stated provision of non- pharmacological interventions can prevent Resident 5 from taking Ativan unnecessarily which can make him sleepy and drowsy preventing him from participating in his 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 interview and record review on 2/11/2026 at 3:32 p.m. with the Director of Nursing (DON), Resident 5's Order Summary Report was reviewed. The DON stated the physician order of Ativan 0.5 mg every 6 hours as needed for anxiety manifested by restlessness should have a stop date and the duration should be 14 days. The DON stated the licensed nurses should assess the behavior, offer non-pharmacological interventions before administering Ativan because there was a potential for side effects like fall, (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confusion and can be unnecessary medicine if administering without attempting to use non-pharmacological interventions. The DON stated Ativan can be a chemical restraint because staff were administering the medicine to quiet Resident 5 down instead of providing non-pharmacological interventions first. The DON stated there should be 14 days stop date for prn Ativan to ensure the resident will not be addicted (very strong urge to do or use something that is very hard to stop or control) to the medicine and develop side effects like drowsiness, dizziness, dry mouth, confusion and sedation which can prevent him from participating in ADLs. During a review of facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, revised 12/2016, the P&P indicated The duration of prn antipsychotic (a type of medication prescribed to treat mental health problem) medications will be indicated in the order. The P&P indicated diagnoses alone do not warrant the use of antipsychotic medications and should only be considered if the behavioral interventions have been attempted.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the recommended ankle-brachial index (ABI- painless test that measures blood pressure in your ankles and arms) with arterial doppler (non-invasive, painless ultrasound test that uses sound waves to evaluate blood flow) for one of 15 sampled residents (Resident 6) was completed as ordered on 1/28/2026 for a right second-toe diabetic ulcer (open sore, commonly on the bottom of the foot, affecting resident with diabetes). This failure resulted in Resident 6 experiencing emotional distress due to uncertainty about whether his toe might require amputation(surgical or traumatic removal of a limb or extremity (arm, leg, finger, toe). Findings: During an observation on 2/9/2026 at 10:05 a.m., at Resident 6's bedside. Resident 6's right second toe was observed to be swollen, black in color with a small amount of blood. During a review of Resident 6's admission Record dated 2/11/2026, the admission Recorded indicated Resident 6 was admitted to the facility on [DATE] with diagnosis including heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), tinea pedis (foot fungus), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's History and Physical (H&P) dated 1/17/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS-resident assessment tool) dated 1/23/2026, the MDS indicated Resident 6's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 6 needed partial/moderate assistance (helper does less than half the work) with activities of daily living (ADL's like dressing, bathing and personal hygiene). During a review of Resident 6's Treatment Administration Record (TAR) dated 2/1/2026, the TAR indicated Resident 6 was being treated for a right second toe diabetic ulcer and to clean with normal saline pat dry apply betadine (kills germs, prevents infection) daily. During a review of Resident 6's Care Plan titled Altered Skin Integrity dated 1/23/2026 revised on 1/30/2026 the Care Plan indicated Resident 6 had right foot tinea pedis (fungal infection of the feet). The Care Plan indicated to have a wound consult and follow-up treatment as indicated. During an interview on 2/10/2026 at 8:04 a.m. with Resident 6, Resident 6 stated about three weeks ago his right second toe began hurting and that it had since started turning black. Resident 6 stated he was worried that his toe might have to be cut off. During a concurrent interview and record review on 2/10/2026 at 3:17 p.m. with the Treatment Nurse (TXN), Resident 6's wound doctor's (Dr.) progress note dated 1/28/2026 was reviewed. The progress note indicated Resident 6 had a recommendation for an ABI and arterial doppler for his right second-toe diabetic ulcer. The TXN stated she was responsible for ensuring the recommendation from the wound care doctor was completed and acknowledged she must have missed it. The TXN stated that the resident's right second toe could worsen, become infected, and potentially require amputation if not properly evaluated. During an interview on 2/12/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated she had been made aware that the recommended ABI and arterial doppler for Resident 6's right second-toe diabetic ulcer had not been completed, and that it should have been done on 1/28/2026. The DON stated there was a possibility of a missed diagnosis. The DON stated she had assessed Resident 6's right second toe, noted it was black, and acknowledged that the resident might require amputation. During a review of the facility's policy & procedure (P&P) titled Physicians Orders dated 2/2014, the P&P indicated verbal, written and telephone orders may be accepted from each residents physician. The receiving nurse will carry out the order and print the medication or treatment record. The new order will be communicated to the responsible party/agent, charge nurse, pharmacy, and other departments as indicated.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents (Resident 4), who had limited range of motion ([ROM] full movement potential of a joint [where two bones meet]) and limited mobility, received appropriate treatment and services to increase ROM, prevent further decline, and maintain or improve mobility. This failure had the potential to place Resident 4 at increased risk for further ROM decline and the development of contractures (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to cerebral infarction (the death of brain tissue resulting from lack of blood supply), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (paralysis of one side of the body) and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 12/16/2025, the MDS indicated Resident 4 never and rarely made decisions regarding task of daily life. The MDS indicated Resident 4 was dependent on nursing staff for rolling from left to right, transferring, toileting, showering, dressing and hygiene. The MDS indicated Resident 4 received zero days of the Restorative Nursing Program([RNA] nursing aide program that helps residents to maintain their function and joint mobility). During an interview on 2/12/2026 at 12:40 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 4 did not have any physician orders for Restorative Nursing Assistant (RNA) services. LVN 1 stated Resident 4 should have RNA services due to left-sided weakness. LVN 1 stated she did not see any current orders for RNA. LVN 1 stated Resident 4 has a care plan addressing mobility deficits. LVN 1 stated Resident 4 had been seen by Physical Therapy (PT a health profession focused on restoring, maintaining, and promoting optimal physical function and mobility) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) but could not recall when those services were last provided. During a review of Resident 4's Care Plan, titled Mobility Deficit, date initiated 6/29/2025, the Care Plan indicated Resident 4 will be referred to the RNA program as prescribed. During an interview on 2/12/2026 at 2:01 p.m. with Restorative Nursing Aide (RNA) 1, RNA 1 stated Resident 4 had previously been receiving RNA services. RNA 1 stated that after Resident 4 was re-admitted from the hospital, no new order for RNA services was received, and the services were not resumed. During an interview on 2/12/2026 at 2:06 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 4 previously had orders for RNA services. The DOR stated that after Resident 4 was readmitted from the hospital, nursing did not reorder RNA services for Resident 4. During an interview on 2/12/2026 at 3:14 p.m. with the Director of Nursing (DON), the DON stated Resident 4 went to the hospital for surgery, and the licensed nursing staff did not re-order RNA services upon the resident's return. The DON stated that Resident 4 should be receiving RNA services and that without them, the resident is at risk of becoming more contracted. During a review of the facility's policy and procedure (P&P), titled Restorative Nursing Services, date revised 7/2017, the P&P indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care .		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure two Certified Nursing Assistants (CNAs) had completed required annual competency evaluations. This failure had the potential to result in residents receiving inadequate care and services due to staff not demonstrating current competency. Findings: During a concurrent interview and record review on 2/12/2026 at 11:06 a.m. with the Director of Nursing (DON), the employee file for CNA 3 was reviewed. The file contained no documentation showing completion of the annual competency. The DON stated CNA 3 did not complete the annual competency and confirmed that annual competencies were required each year. The DON stated that without completing the annual competency, CNA 3 would lack updated knowledge and accountability. During a review of the facility's policy and procedure (P&P) titled Competency of Nursing Staff, dated 3/2025, the P&P indicated All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will participate in a facility-specific, competency-based staff development and training program and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's Quality Assessment and Assurance (QAA a group of people developing and monitoring quality compliance) Committee, failed to ensure effective oversight of facility operations and failed to ensure implementation of the 2025 Plan of Correction (POC) addressing deficient practices identified during the previous 2025 recertification survey. This failure resulted in repeat deficiencies in food storage, food preparation, and sanitation, as well as failure to ensure required annual in-service training for Certified Nursing Assistants (CNAs) was completed. Findings: During a review of the facility's Statement of Deficiencies, dated 5/18/2025, the statement of deficiencies indicated the following repeat deficiencies in food storage, preparation and sanitation and in the required yearly in-service training (education) for the CNA's. During a concurrent interview and record review on 2/12/2026 at 11:42 a.m. with the Administrator (ADM), the facility's Quality Assurance and Performance Improvement (QAPI a data driven proactive approach to improvement used to ensure services are meeting quality standards) plan was reviewed. The ADM stated that QAPI was a program the facility uses to track issues and implement improvements to enhance residents' quality of life. The ADM stated there were deficiencies cited during last year's survey related to the kitchen and CNA education, and stated the facility was not currently working on those areas. The ADM stated the facility would begin addressing these issues to ensure resident safety. During a review of the facility's policy and procedure (P&P) titled Quality Assurance Performance Improvement (QAPI) Program dated 11/2017, the P&P indicated The QAPI program is an integrated, comprehensive organizational-wide methodology used to continuously examine, refine. And revise processes and systems to meet or exceed the needs of those we serve. It is the integration of fundamental management approaches, improvement efforts, tools, and training and is driven by the results of the facility annual assessment findings. It is the policy that a functional QAPI program is maintained to monitor and evaluate the quality of resident's care and services, pursue methods to improve quality and all areas of organizational functioning, and to promote safety by using a systematic problem identification and resolution process. The facility QAPI program incorporates the findings in the annual facility assessment into key elements of the program.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure:a. Education was provided about the benefits and risks of the COVID-19 (an illness caused by the coronavirus and affects the lungs and breathing and can make other parts of the body sick) vaccine for one of five residents (Resident 4) and/or the resident's representative.b. One of five staff (Dietary Aide 1) had documentation containing information demonstrating the staff member had been screened, provided with COVID-19 vaccine education, was offered the vaccine and had their current vaccination status recorded.This failure had the potential to result in residents and staff remaining unprotected against COVID-19, increased risk of serious illness, delayed identification of vaccine status, and missed opportunities to prevent the spread of infection within the facility.Findings:a. During a review of Resident 4's Face Sheet (admission Record), the Face Sheet indicated the facility originally admitted Resident 4 on 9/14/2024 and was re-admitted on [DATE] with diagnoses including frontal lobe (part of the four major lobes in the human brain) and executive function deficit following cerebral infarction (cerebral infarction - blocked blood flow to the brain resulting in tissue death).During a review of Resident 4's history and physical (H&P) dated 11/12/2025, the H&P indicated Resident 4 does not have the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/16/2025, the MDS indicated Resident 4 had severely impaired cognitive skills for daily decision making.During a concurrent interview and record review on 2/11/2026 at 1:30 p.m. with the Licensed Vocational Nurse (LVN)1 Resident 4's immunization screening was reviewed. Resident 4 immunization record indicated COVID-19 vaccination was given on 10/3/2025 and the vaccination informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was received over the phone from the responsible party on 9/17/2025. LVN 1 stated there was no documentation the resident's responsible party was given education for the vaccine. LVN 1 stated the importance of providing education to the resident and the responsible party was to explain the risks of not receiving the vaccine and benefits of receiving the vaccine.During a concurrent interview and record review on 2/11/2026 at 2:50 p.m. with the Infection Preventionist Nurse (IPN), Resident 4's immunization screening was reviewed. The IPN stated vaccination education was not given. The IPN stated the resident's responsible party should have been educated for the COVID-19 vaccine. The IPN stated the importance of providing education was to explain the risk and benefits of the vaccine.b. During a concurrent interview and record review interview on 2/11/2026 at 2:50 p.m. with the Infection Preventionist Nurse (IPN). Dietary Aide (DA) 1 had no documentation of COVID-19 vaccine, or COVID-19 vaccine education. The IPN stated no COVID-19 vaccine had been offered. The IPN stated the risk to the resident if staff do not have vaccine was transmitting the virus.During a review of the facility's policy and procedure (P&P) titled COVID-19, Prevention and Control revised 4/4/2025, indicated All health care providers will be provided information regarding the requirement to receive the COVID-19 vaccine.The IP nurse or a facility designated staff shall obtain and document the current vaccination status of all health care providers including but not limited to COVID-19 immunization.		

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure adequate room size and space to support the comfort and well-being of one of 46 sampled residents (Resident 34). This failure had the potential to negatively impact Resident 34's quality of life by limiting his ability to move freely and safely within his living space. 2. Ensure 18 of 24 residents' rooms (room [ROOM NUMBER], 102, 103, 104, 106, 107, 108, 109, 110, 116, 118, 215, 217, 219, 221, 223, 229, 231) met the requirements of 80 square feet for each resident. This failure had the potential to result in inadequate provision of safe nursing care and a lack of privacy for residents. Findings: During a review of Resident 34's admission Record dated 2/12/2026, the admission Record indicated Resident 34 was admitted to the facility on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and cerebrovascular accident (CVA stroke, loss of blood flow to a part of the brain). During a review of Resident 34's History & Physical (H&P), dated 10/16/2025, 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-resident assessment tool) dated 1/16/2026, the MDS indicated Resident 34's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 34 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living (ADLs- like dressing, bathing and personal hygiene). During an interview on 2/12/2026 at 8:52 a.m. in Resident 34's room, Resident 34 stated his room was way too small and that it was intended for only one person. Resident 34 stated he does not leave his room often because it takes too much time to move his belongings out of the way in order to exit. During a concurrent interview and record review on 2/12/2026 at 11:56 a.m. with the Administrator (ADM), reviewed of the facility's Waiver Request on Room Variance (WRRV), dated 2/09/2026, which indicated the facility had 18 rooms measuring less than the required 80 square feet per resident. The WRRV stated the requested variance would not compromise the health, welfare, or safety of residents. The following rooms were identified: room [ROOM NUMBER] (2 beds) 152.39 sq. ft., room [ROOM NUMBER] (2 beds) 155.28 sq. ft., room [ROOM NUMBER] (2 beds) 157.92 sq. ft., room [ROOM NUMBER] (2 beds) 159.00 sq. ft., room [ROOM NUMBER] (2 beds) 152.37 sq. ft., room [ROOM NUMBER] (2 beds) 156.49 sq. ft., room [ROOM NUMBER] (2 beds) 152.37 sq. ft., room [ROOM NUMBER] (2 beds) 154.21 sq. ft., room [ROOM NUMBER] (2 beds) 154.21 sq. ft., room [ROOM NUMBER] (2 beds) 157.69 sq. ft., room [ROOM NUMBER] (2 beds) 156.36 sq. ft., room [ROOM NUMBER] (2 beds) 151.02 sq. ft., room [ROOM NUMBER] (2 beds) 151.02 sq. ft., room [ROOM NUMBER] (4 beds) 318.55 sq. ft., room [ROOM NUMBER] (2 beds) 150.12 sq. ft., room [ROOM NUMBER] (2 beds) 149.98 sq. ft., room [ROOM NUMBER] (2 beds) 147.29 sq. ft., room [ROOM NUMBER] (2 beds) 147.29 sq. ft. The ADM stated the rooms were small and that the facility does its best to ensure residents were comfortable. During a review of the facilities policy and procedure (P&P) titled Accommodation of Needs dated 3/2021, the P&P indicated, our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure two Certified Nursing Assistants (CNAs) completed the required 12 hours of annual in-service training. This failure had the potential to result in a lack of, or delay in, necessary care and interventions for residents due to staff not maintaining required knowledge and skills. Findings: During a concurrent interview and record review on 2/12/2026 at 11:06 a.m. with the Director of Nursing (DON), the employee files for Certified Nursing Assistant (CNA) 3 and CNA 4 were reviewed. The files showed no documentation that CNA 3 completed the required 12 hours of annual nurse aide in-service training. The DON stated that CNA 3 had not completed the required annual in-services. The file for CNA 4 showed that the last completion of the required 12 hours of annual in-services was on 4/29/2024. The DON stated that the annual 12-hour in-service requirement must be completed each year. The DON stated CNAs who do not complete their required in-services will lack the necessary knowledge to provide proper care and will have no accountability. The DON stated the facility does not currently have a Director of Staff Development (DSD) and stated, I need a DSD that is good with teaching. During a review of the facility's policy and procedure (P&P) titled Certified Nursing Assistant, dated 5/2017, the P&P indicated CNAs must attend a minimum of 12 hours continuing education programs provided by the center in order to maintain certification.		