STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555599	A. Building B. Wing	01/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrance Memorial Med Ctr Snf/Dp	3330 West Lomita Blvd Torrance, CA 90505

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review the facility failed to notify the physician on one of four sampled residents (Resident 122) by: 1. Failing to notify the physician and document a change in condition when Resident 122 had an episode of nausea and vomiting and refusal to eat. This failure had the potential to delay treatment or care for Resident 122. Findings: During a review of Resident 122's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility. During a review of Resident 122's History and Physical (H & P) dated 1/7/2025, the H & P indicated the resident was admitted with diagnoses that included history of breast cancer (a disease when an abnormal breast cells grow out of control and form tumors in the breast which was treated in the past), metastatic disease to the bone (cancer that had spread to the bone), atrial fibrillation(heart condition that causes an irregular heart beat), stage 3 pressure ulcer (full thickness loss of skin and dead and black tissue may be visible) and hypothyroidism(when the thyroid gland does not make enough thyroid hormone which can lead to health problems). During a review of Resident 122's Minimum Data Set (MDS- a resident assessment tool) dated 1/13/2025, the MDS indicated the resident was rarely or never understood and had moderately impaired cognitive skills for daily decision making (problem with a person's ability to think, learn, remember, use judgment, and make decisions). The MDS indicated the resident is dependent on staff with transfer to and from a bed to chair, eating, oral hygiene, toileting hygiene, bathing, and personal hygiene. During a review of Resident 122's Care Plan titled LTC Gastrointestinal IPOC' initiated 1/18/2025, the Care Plan indicated interventions that included evaluating possible causes of nausea and vomiting, using nursing care measures for nausea/ vomiting as indicated and evaluating the resident for abdominal distension(swelling and becoming large by pressure from inside characterized by symptoms of trapped gas , abdominal pressure, and fullness) ,tenderness and bowel motility (gut movement). (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 122's Interdisciplinary Summary datedSummary dated 1/17/2025 and timed at 4:00 p.m. indicated the resident had an episode of vomiting after lunch and anti-nausea medication was refused by the Family Member (FM1). During a review of Resident 122's meals meal intake dated 1/17/2025 and 1/18/2025, the meal intake for 1/17/2025 indicated the resident ate breakfast and lunch but did not have dinner. The meal intake for 1/18/2025 indicated the resident did not eat lunch. During a review of Resident 122's meal intakes from 1/9/2025 to 1/17/2025, the resident was only eating breakfast and lunch. During an interview on 1/18/2025, at 3:54 p.m. with Certified Nursing Assistant (CNA2), CNA 2 stated Resident 122 did not receive a lunch tray today because Family Member (FM1) did not order any food due to resident's upset stomach. During a concurrent interview and record review of Resident 122's electronic Record on 1/18/2025, at 4:18 p. m. with Registered Nurse (RN3), RN 3 confirmed on 1/17/25, Resident 122 had an episode of nausea and vomiting, and the physician was not notified and change of condition was not documented. RN 3 stated on 1/18/2025, FM1 spoke to her before lunch that she cancelled the lunch tray of the resident because the resident did not want to eat. RN 3 stated she should have talked to the physician about resident's refusal to eat and ordered a lunch tray even FM1 cancelled the tray. During a concurrent interview and record review of Resident 122's electronic chart on 1/19/2025, at 3:36 p. m. with Director of Staff Development (DSD), DSD stated the licensed nurses document the change in condition in the Interdisciplinary Summary under Nurses Notes and CNA's document the meal intake in real time. DSD stated nausea and vomiting is a change in condition. DSD stated the nurse should have assessed, notify the physician about the episode of nausea and vomiting and documented a change in condition. DSD stated it is important to notify the physician for medical intervention and obtain order for treatment to prevent causing delay of treatment and care. During an interview on 1/19/2025, at 4:08 p.m. with Director of Nursing (DON), DON stated it is important for the licensed nurses to communicate directly to the physician about what the resident needs and problem because information coming from the family could be inaccurate and can cause a delay in care. DON stated it is important to notify the physician for any change in condition of a resident to obtain orders for treatment or medical intervention. During a review of facility's policy and procedure (P&P) titled Change in Resident's Condition or Status dated 4/3/2024, the P&P indicated nursing will notify the resident's attending physician when there is a change in condition. The P&P indicated the Transitional Care Unit will notify the physician, resident and resident representative when there is a change in condition including a significant change in the resident's physical, mental or psychosocial status or a need to alter

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to provide services which meet professional standards of quality for one of four sampled residents (Resident 12) by failing: 1. To ensure vital signs (measurements of the body's most basic functions such as heart rate, breathing rate, blood pressure, and temperature) were obtained before administering medications that can affect blood pressure(bp- force of blood pushing against the walls of the arteries). 2. To ensure vital signs reading taken two hours ago before administration of an anti-hypertensive medicines (medicines that are used to lower high blood pressure) was not used as a parameter(limit that affects how something is done) to administer the medicine. These failures have the potential to put Resident 12 at risk for hypotension (low blood pressure) that could lead to fall. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included hypertension (high blood pressure), diabetes (DM- a disorder characterized by difficulty in blood sugar and poor wound healing),and aphasia(a disorder that makes it difficult to speak). During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool) dated 12/28/2024, the MDS indicated the resident had moderately impaired cognitive skills for daily decision making and was dependent (helper does all the effort) on staff with eating, oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene. The MDS indicated the resident required substantial assistance (helper does more than half the effort) with bed mobility and transfer to and from bed a bed to chair. During a review of Resident 12's Vital Signs Record dated 1/19/2025 indicated resident's blood pressure was 101/53, and heart rate 64 beats per minute taken at 7:07 a.m. During a medication administration observation on 1/19/2025 , at 8:40 a.m. with Registered Nurse (RN1), observed RN 1 administered Amlodipine (medicine used to treat high blood pressure) 2.5 milligrams (mgs- unit of measurement) one tablet and lisinopril 10 mgs one tablet to Resident 12 without taking resident's blood pressure. During an interview on 1/19/2025, at 12:54 p.m. with RN 1, RN 1 stated she would usually use the blood pressure and heart rate taken by Certified Nursing Assistants from 6:30 a.m. to 7:00 a.m. when passing medicines that could lower the blood pressure. RN 1 stated she was told by the facility that it's alright to use the result of vital signs taken two hours ago before medication administration. RN 1 stated for Resident 12, she used the blood pressure reading taken around 7:00 a.m. on 1/19/2025. RN1 stated there is a possibility of hypotension (low blood pressure), dizziness and fall if lisinopril and amlodipine were given, and blood pressure was not checked before administering them. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/19/2025, at 4:05 p.m. with Director of Nursing (DON), DON stated the licensed nurse should reach out to the physician to discuss any changes on resident's condition and obtain a parameter to hold the medicine. DON stated there was no policy or defined time frame indicating it was alright to use vital signs taken in the morning around 7:00 a.m. or taken two hours ago to use as a basis to administer the cardiac medicines for 9:00 a.m. DON stated the resident could develop hypotension , lightheadedness or fall if the resident's blood pressure is not taken before administering it to the resident because the bp might be lower than what was taken from 7:00 a.m. During a review of an online article from National Library of Medicine updated 7/24/2024 titled Hypertensive Emergency (Nursing) indicated to monitor blood pressure frequently and know the target set by the physician. https://www.ncbi.nlm.nih.gov/books/NBK568676/. During a review of an online article from National Library of Medicine titled Blood Pressure Assessment in Adults in Clinical Practice and Clinic-Based Research: JACC Scientific Expert Panel - PMC Volume 73, Issue 3, published 1/29/2019, the online article indicated the primary purpose of measuring bp in routine clinical practice are to screen for hypertension and hypotension , and to monitor the response to antihypertensive treatment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49145 Based on observation and interview the facility failed to ensure staffing information was posted and placed in a visible and prominent place daily. This deficient practice resulted in unavailable information for the number of staff and actual hours worked daily that is visible for residents, staff and visitors. Findings: During an observation 1/19/2025 at 11:30 a.m., no visible staffing information was found on station 1 or station 2. During an observation on 1/19/2025 at 11:30 a.m., no visible staffing information was found in the lobby or upon entrance to the unit. During an interview on 1/19/2025 at 11:49 a.m., with Registered Nurse (RN) 1, RN 1 stated there is no staffing information visibly posted for the residents and visitors. During an interview on 1/19/2025 at 11:52 a.m., with the Director of Staff Development (DSD), the DSD stated that there is a staffing information form posted in station 1 but is not facing outward for residents and visitors to see and probably should be. During an interview on 1/19/2025 at 3:42 p.m., with the Director of Nursing (DON), the DON stated the nurse staffing hours were not posted for residents and visitors to see but should be, so they are aware they are following the regulation and are aware of the staffing for each day.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure one of 12 sampled residents (Resident 2) was free from receiving an unnecessary antibiotic, to treat a skin tear (a wound that occurs when the skin separates due to friction, blunt force, or shear). This failure had the potential for Resident 2 to experience adverse side effects, antibiotic resistance and to receive an inappropriate antibiotic. Findings: During a review of Resident 2's Registration Record, the Registration Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 12/17/2024, the H&P indicated Resident 2 had diagnoses of but not limited to a skin tear of the lower leg without complication, pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) with left lower leg weakness. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 2 had the ability to understand others and had the ability to express wants and ideas. The MDS indicate Resident 2 was dependent on nursing staff for lower body dressing, putting on and taking off footwear, showering and transferring from the bed to chair. The MDS indicated Resident needed substantial to maximal assistance from nursing staff with oral hygiene, toileting upper body dressing, and personal hygiene. The MDS indicated Resident 2 needed substantial to maximal assistance from nursing staff with rolling from left to right, sitting, standing and lying flat on the bed. The MDS indicated Resident 2 needed partial to moderate assistance from staff with eating. During a review of Resident 2's Physician Orders, the Physician Orders indicated Resident 2 had an order for clindamycin (medication used to treat various types of infections, including skin and vaginal infections) 300 milligrams, two capsules by mouth every eight hours for cellulitis (a skin infection that causes swelling and redness) of the right leg starting on 12/18/2024 to 12/25/2024. During a concurrent interview and record review on 1/19/2025 at 9:33 a.m. with the Infection Preventionist (IP), Resident 2's Hospitalist Progress Notes, dated 12/20/2024 was reviewed. The Hospitalist Progress Notes indicated, Resident 2 had right leg cellulitis from a skin tear. The Hospitalist Progress Notes indicated Resident 2's skin tear was red and hot. The Hospitalist Progress Notes indicated Resident 2's was started on clindamycin. The IP stated Resident 2 was admitted to the facility on [DATE] and started on clindamycin on 12/18/2024. The IP stated no culture was done before the antibiotic were administered to Resident 2. The IP stated Resident 2 did not have a fever, elevated white blood cells and had no drainage from the skin tear. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/19/2025 at 12:48 p.m. with the IP, the facility's policy and procedure (P&P) titled Surveillance Definitions, dated 1/2025 was reviewed. The P&P indicated, Skin infections must meet at least one of the following criteria: Patient has at least one of the following purulent drainage, pustules, vesicles, boils (excluding acne). Patient has at least two of the following localized signs or symptoms: pain* or tenderness*, swelling*, erythema *, or heat* and at least one of the following: organism(s) identified from aspirate or drainage from affected site by a culture or non-culture-based testing method which is performed for purposes of clinical diagnosis and treatment The IP stated Resident 2 did meet the NHSN criteria for a skin infection. The IP stated this should have been discussed with the physician. The IP stated Resident 2 could develop c-diff or a multi drug resistant organism. During an interview on 1/19/2025 4:04 p.m. with the Director of Nursing (DON), the DON stated Resident 2 had the potential to develop side effects and resistance to antibiotics after taking antibiotics and not meeting the NHSN criteria. During a review of the facility's policy and procedure (P&P) titled, Transitional Care Unit (TCU) Drug Indication Review Protocol, date revised 4/21/2015, the P&P indicated Pharmacy, in accordance with Title 42 of the Code of Federal Regulations section 483.60c, will perform a weekly drug regimen review. If a drug and corresponding indication is clearly delineated as part of the medical record, the pharmacist will transcribe that information onto the physician orders. If a drug does not have a clear indication, the pharmacist will clarify the diagnosis with the physician or take measures to discontinue the medication.

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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. 44898 Based on observation, interview and record review, the facility failed to ensure: a. opened, unlabeled and undated bag of pepperonis with freezer burns was not stored in the freezer and was discarded. b. the temperature on a High Temperature Dishwasher wash cycle was 150 degrees Fahrenheit. These failures had the potential to result in residents eating compromised quality of meat due to dryness and altered texture and had the potential to result in residents being exposed to rapid growth of bacteria that can cause foodborne illness (food poisoning). Findings: During a concurrent observation and interview on 1/17/2025 at 5:00 pm, with Manager of Patient Services (MOPS) in the kitchen, Freezer #14 had an unlabeled open bag of pepperonis with freezer burns. During an interview on 1/19/2025 at 10:55 pm with Dishwasher (DW) 1, DW 1 stated when washing dishes the temperature is 150 degrees Fahrenheit. DW 1 stated it is important to wash dishes at 150 degrees Fahrenheit to kill the bacteria. During an observation on 1/19/2025 at 11:37 am in the kitchen, the temperature on the dishwasher wash cycle temperature ranged from 144 degrees Fahrenheit to 146 degrees Fahrenheit. During an interview on 1/19/2025 at 2:10 p.m. with Lead Food Service Supervision, LFSS stated after food is opened in the freezer the food is put in a plastic bag and labeled and dated. LFSS stated all food items are labeled and dated so we know the last day it can be used and the name of the person who opened it. LFSS stated food with freezer burn is discarded because the presentation and taste will not be good. LFSS stated the temperature on the dishwasher wash cycle is 147 to 149 degrees Fahrenheit and the manger was notified to get it fixed. The LFSS stated the goal is 150 degrees Fahrenheit to kills germs and bacteria based on the facility's policy. During a review of the facility's policy and procedure (P&P) titled, Food Storage, dated 9/12/2023, the P&P indicated Date products to ensure the use of first in first out (FIFO procedures .Label and date products per regulatory standards . Store all leftovers cold food in storage containers and completely cover with plastic or foil wrap. Label and date the containers and place them in the refrigerator. During a review of the facility's policy and procedure (P&P) titled, Infection Control, Food Safety and HACCP (Hazard analysis and Critical Control Point), dated 9/12/2023, the P&P indicated the purpose is to To ensure the safety and quality of the food served to patients, visitors, and staff . Dish machine wash water should be 150 degrees Fahrenheit or greater.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure one of 12 sampled residents (Resident 2) was free from receiving an unnecessary antibiotic, to treat a skin tear (a wound that occurs when the skin separates due to friction, blunt force, or shear). This failure had the potential for Resident 2 to experience adverse side effects, antibiotic resistance and to receive an inappropriate antibiotic. Findings: During a review of Resident 2's Registration Record, the Registration Record indicated Resident 2 was admitted to the facility on [DATE]. During a review of Resident 2's History and Physical (H&P), dated 12/17/2024, the H&P indicated Resident 2 had diagnoses of but not limited to a skin tear of the lower leg without complication, pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) with left lower leg weakness. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/23/2024, the MDS indicated Resident 2 had the ability to understand others and had the ability to express wants and ideas. The MDS indicate Resident 2 was dependent on nursing staff for lower body dressing, putting on and taking off footwear, showering and transferring from the bed to chair. The MDS indicated Resident needed substantial to maximal assistance from nursing staff with oral hygiene, toileting upper body dressing, and personal hygiene. The MDS indicated Resident 2 needed substantial to maximal assistance from nursing staff with rolling from left to right, sitting, standing and lying flat on the bed. The MDS indicated Resident 2 needed partial to moderate assistance from staff with eating. During a review of Resident 2's Physician Orders, the Physician Orders indicated Resident 2 had an order for clindamycin (medication used to treat various types of infections, including skin and vaginal infections) 300 milligrams, two capsules by mouth every eight hours for cellulitis (a skin infection that causes swelling and redness) of the right leg starting on 12/18/2024 to 12/25/2024. During a concurrent interview and record review on 1/19/2025 at 9:33 a.m. with the infection Preventionist (IP), Resident 2's Hospitalist Progress Notes, dated 12/20/2024 was reviewed. The Hospitalist Progress Notes indicated stated Resident 2 had right leg cellulitis from a skin tear. The Hospitalist Progress Notes indicated Resident 2's skin tear was red and hot. The Hospitalist Progress Notes indicated Resident 2's was started on clindamycin. The IP stated Resident 2 was admitted to the facility on [DATE] and started on clindamycin on 12/18/2024. The IP stated no culture was done before the antibiotic were administered to Resident 2. The IP stated Resident 2 did not have a fever, elevated white blood cells and had no drainage from the skin tear. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/19/2025 at 12:48 p.m. with the IP, the facility's policy and procedure (P&P) titled Surveillance Definitions, dated 1/2025 was reviewed. The P&P indicated, Skin infections must meet at least one of the following criteria: Patient has at least one of the following purulent drainage, pustules, vesicles, boils (excluding acne). Patient has at least two of the following localized signs or symptoms: pain* or tenderness*, swelling*, erythema *, or heat* and at least one of the following: organism(s) identified from aspirate or drainage from affected site by a culture or non-culture based testing method which is performed for purposes of clinical diagnosis and treatment. The IP stated Resident 2 did meet the NHSN criteria for a skin infection. The IP stated this should have been discussed with the physician. The IP stated Resident 2 could develop c-diff or a multi drug resistant organism. During an interview on 1/19/2025 4:04 p.m. with the Director of Nursing (DON), the DON stated Resident 2 had the potential to develop side effects and resistance to antibiotics after taking antibiotics and not meeting the NHSN criteria. During a review of the facility's policy and procedure (P&P) titled, Medication Management-Antibiotic Stewardship Program, dated 11/1/2023, the P&P indicated, The purpose of antibiotic stewardship team is to formulate clinical, multi-disciplinary strategies around anti- infective therapy. Our mission is to mitigate over utilization of anti-infectives that may lead to adverse patient outcomes as well as promote the timely administration of appropriate, life-saving anti-infective treatments to meet the needs of our community.