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	03/15/2026

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** Based on interview and record review the facility failed to notify the physician of a change of condition for one of one sampled residents (Resident 35) when Resident 35's oxygen saturation ([O2 sat]- a measurement of how much oxygen the blood is carrying as a percentage) decreased to 90 percent ([%] a number or ratio expressed as a fraction of 100) on room air (normal O2 sat is 92% -100%).This failure resulted in Resident 35 experiencing respiratory distress, agitation and being transferred to the General Acute Care Unit (GACH) for evaluation and treatment.Findings:During a review of Resident 35's admission record, the admission record indicated Resident 35 was admitted to the facility on [DATE] with diagnosis including a left femoral (thigh bone) open reduction and internal fixation (ORIF-surgery used to stabilize and heal a broken bone) that required rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being), stroke (loss of blood flow to part of the brain), and non-traumatic brain dysfunction (an injury to the brain caused by chemical and toxins in the body).During a review of Resident 35's Minimum Data Set(MDS- a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 35 had some difficulty with daily decision making. The MDS indicated Resident 35 was dependent (helper does all the effort) on nursing staff for eating, oral hygiene, toileting, dressing, and showering. The MDS indicated Resident 35 needed substantial to maximal assistance (helper does all the effort) with sitting, standing, lying down and transferring. During an interview on 3/15/2026 at 3:06 p.m. with Registered Nurse (RN) 1, RN 1 stated on 1/28/2025 at 6:30 a.m. Resident 35's oxygen saturation was 90%. RN 1 stated Resident 35 had acute respiratory failure (the inability of the respiratory system to maintain an adequate blood oxygen level) and had a Rapid Response (a team of providers summoned to the bedside to immediately assess and treat the resident with the goal of preventing intensive care unit transfer, cardiac arrest, or death) on 1/29/2026. RN 1 stated the doctor should have been notified and a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) should have been documented. RN 1 stated oxygen saturation of 90% is low. RN 1 stated there was no documentation in Resident 35's chart that the doctor was notified. RN 1 stated a when Resident 35's oxygen saturation decreased to 90% an assessment and notification to the doctor should have been done. RN 1 stated rapid response could have been avoided. During an interview on 3/15/2026 at 3:35 p.m. with RN 2, RN 2 stated there was no documentation of the doctor being notified or the reason Resident 35 was placed on oxygen. RN 2 stated licensed nurses are supposed to notify the doctor if a resident is distressed or having trouble breathing. RN 2 stated that an oxygen saturation of 90% is low and a COC should have been documented.During an interview on 03/15/2026 at 4:24 p.m. with the Director of Nursing (DON), the DON stated on 1/28/2026 Resident 35's oxygen dropped to 90%. The DON stated a notification to the physician for intervention needed to be done at the time of the resident's change of condition and documented in the Nursing Progress Notes.During a review of Resident 35's Physician Progress Notes, dated 1/28/2026 at 5:03 p.m., the Physician Progress Notes indicated Resident 35's (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	oxygen saturation was 90% on 1/28/2026 at 6:32 a.m.During a review of Resident 35's Physician Progress Notes, dated 1/29/2026 at 4:32 p.m. the Physician Progress Notes indicated Nursing staff noticed Resident 35 was lethargic and noticed coughing and rales (small clicking, bubbling, or rattling sounds in the lungs) were heard during a lung exam. The Physician Progress Notes indicated Resident 35 felt hot and had changes in mental status, a cough and new hypoxia (condition when the body does not get enough oxygen). The Physician Progress Notes indicated Resident 35 had a chest x-ray on 1/29/2026 at 4:21 p.m. that resulted in Resident 35 having a right basilar pleural-parenchymal opacity (disease that affect the air spaces of the lungs), presenting a combination of effusion (water in the lungs), atelectasis, and/or developing consolidation and mild pulmonary vascular congestion. During a review of Resident 35's Rapid Response Event Summary, dated 1/29/2026 at 9:10 p.m., the Rapid Response Event Summary indicated the Rapid Response Team was called for worsening respiratory distress and agitation of Resident 35. The Rapid Response Event Summary indicated Resident 35 respiratory rate (the number of breaths a person takes per minute) was 42 (normal 12-20 breaths per minute), the blood pressure was 195/87, the pulse oximetry (a test used to measure the oxygen level (oxygen saturation) of the blood) was 84% with room air and the oxygen saturation improved to 95% with 3 liters of oxygen given by nasal cannula. The Rapid Response Event Summary indicated Resident 35 was transferred to the GACH on 1/29/2026 at 10:15 p.m During a review of the facility's policy and procedure (P&P), titled Change in Resident's Condition or Status, dated 7/1/2021, the P&P indicated The Transitional Care unit will inform the resident; consult with the resident's physician; and notify the resident representative when there is a change in condition or status of a resident.Nursing will notify the resident attending physician when there is a change in condition or status immediately or ASAP.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 was competent in providing one to one care ([1:1 sitter] provides constant supervision to a single patient to ensure safety) for one of one residents (Resident 38) who was diagnosed with suicidal ideations (death caused by injuring oneself with the intent to die) in the facility.This deficient practice had the potential to affect Resident 38 and all residents requiring close observation, and placed them at risk for self-harm, hospitalization and death.Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE].During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) dated 3/13/2026, the MDS indicated Resident 38's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 38 was dependent (helper does all the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During a review of Resident 38's physician orders dated 3/13/2026 at 6:39 p.m., the physician orders indicated an order for a sitter to observe Resident 38 for suicidal ideations.During a review of Resident 38's History and Physical (H&P) dated 3/15/2026, the H&P indicated Resident 38 had diagnoses of atrial fibrillation (AFIB- irregular heart rate), paraspinal mass (tumor that develops in the area of the spine), and hypertension (HTN- high blood pressure).During a concurrent observation and interview on 3/14/2026 at 10:05 a.m., in Resident 38's room, Licensed Vocational Nurse (LVN) 1 was sitting at Resident 38's bedside. LVN 1 stated she was a 1:1 sitter for Resident 38 because he was a high-fall risk, confused, and tries to get out of bed without calling.During a telephone interview on 3/14/2026 at 11:44 a.m., with Resident 38's daughter, Resident 38's daughter stated he had a 1:1 sitter because Resident 38 told her that he wanted to hurt himself and die and if given the chance.During an interview on 3/15/2026 at 1:54 p.m., with Registered Nurse (RN) 2, RN 2 stated Resident 38 had a 1:1 sitter because he (Resident 38) made a comment about wanting to die. RN 2 stated LVN 1 should have known why Resident 38 needed to have a 1:1 sitter so she was aware of what to watch for, prevent Resident 38 from harming himself, and for Resident 38's safety.During an interview on 3/15/2026 at 5:54 p.m., with the Director of Nursing (DON), the DON stated LVN 1 should have known why she was 1:1 for Resident 38. The DON stated it should have been communicated appropriately so LVN 1 would know what to look for in Resident 38's behaviors, mood, attempts to harm himself and for the safety of Resident 38.During a review of the facility's policy and procedure (P&P) titled, Sitter, Patient Support Personnel dated 2/1/2025, the P&P indicated, The responsibilities of the sitter support staff include, obtaining a patient condition report prior to engaging in care activities, taking responsible steps to ensure that the patient does not harm him/herself or others, reporting any changes in mental status, physical status to the primary nurse immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices by failing to:Ensure staff change gloves after picking up a dirty trashcan and before passing medications to one of three sampled residents (Resident 4).Ensure visitors followed Enhanced Barrier Precautions (EBP- infection control steps requiring staff to wear gowns and gloves during high-contact care [dressing, bathing, or changing linen] for residents with, or at risk of, germ-resistant infections) for one of three sampled residents (Resident 40).These failures had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place all residents at risk for spread of infection.Findings:1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility 2/3/2026.During a review of Resident 4's History and Physical (H&P) dated 2/4/2026, the H&P indicated Resident 4 was admitted with diagnoses including intracerebral hemorrhage (bleeding into the brain tissue) and acute respiratory failure (the lungs can't release enough oxygen into your blood).During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 2/10/2026, the MDS indicated Resident 4's cognition (ability to think, understand, learn, and remember) was moderately impaired. The MDS indicated Resident 4 was dependent (helper does all of effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily).During a concurrent observation and interview on 3/15/2026 at 9:22 a.m., during a medication pass observation with Registered Nurse (RN) 2, RN 2 was observed preparing Resident 4's medications while wearing gloves, went to retrieve the trashcan, and then went back to preparing medications without changing gloves or performing hand hygiene. RN 2 stated she should have washed her hands and changed her gloves after picking up the trashcan because the trashcan is dirty and to prevent cross-contamination and infection for Resident 4.During an interview on 3/15/2026 at 11:03 a.m., with the Infection Prevention Nurse (IPN), IPN stated RN 2 should have washed her hands and changed her gloves after touching the trash can while passing medications because it could cause an infection for Resident 4.During an interview on 3/15/2026 at 5:54 p.m., with the Director of Nursing (DON), the DON stated RN 2 should have washed her hands and changed gloves after touching the trashcan to prevent an infection.During a review of the facility's policy and procedure (P&P) titled, Standard Transmission Based Isolation Precautions, dated 1/1/2020, the P&P indicated, Standard precautions are designed to ensure a safe environment and reduce the potential for transmission of infection to both patients and healthcare personnel. Gloves should be removed after contact with a patient and/or the surrounding environment.2. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE].During a review of Resident 40's H&P dated 3/9/2026, the H&P indicated Resident 40 was admitted with diagnoses of lip hip fracture (broken bone) and hypertension (HTN- high blood pressure).During a review of Resident 40's Social Work Adult Psychosocial assessment dated [DATE], the Social Work Adult Psychosocial Assessment indicated Resident 40's cognition was intact.During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 4 was dependent on ADLs.During a review of Resident 40's Order's, the Order's indicated an order, dated 3/14/2026, for EBP isolation for an unhealed surgical incision.During a concurrent observation and interview on 3/14/2026 at 10:12 p.m., with the Director of Staff Development (DSD), Resident 40's visitor was observed in the room assisting Resident 40 to sit up in bed and assist to the chair without wearing appropriate personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). The DSD stated the caregiver should be wearing PPE while providing care for Resident 40 to prevent the spread of infection.During an interview on 3/14/2026 at 10:30 a.m., with the IPN, the IPN stated the facility encourages visitors to wear the appropriate PPE if they provide high-contact care. The IPN stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visitors not wearing PPE could result in the transmission of infection to the residents.During an interview on 3/15/2026 at 5:54 p.m., with the DON, the DON stated visitors should be wearing PPE for the safety of the residents and to prevent the spread of infection.During a review of the facility's P&P titled, Standard Transmission Based Isolation Precautions, dated 1/1/2020, the P&P indicated, EBP is a resident-centered and activity-based approach for preventing multi-drug-resistant organism (MDROs) transmission during high-contact care with any resident with surgical (unhealed) wounds. Visitors are to be educated by the staff on how to wear appropriate PPE for patients in isolation.During a review of the facility's P&P titled, Visiting Hours dated, 1/1/2020, the P&P indicated, Visitors must adhere to the isolation protocol.