STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055559	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Crest Care Center	3750 Garnet Street Torrance, CA 90503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure the care plan for one of three sampled residents (Resident 2), who had a history of wandering into other residents' rooms, care plan for a one to one (1:1) sitter (a healthcare worker who provides constant, continuous observation to a single resident to ensure their safety and prevention potential harm), was implemented. This deficient practice resulted in Resident 2 Resident 1's room without Resident 1's consent or the facility staff's knowledge and attempting to take Resident 1's cell phone. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental disease that is characterized by disturbances in thought), a mood disorder (a mental health condition that affects a person's emotional state involving extreme mood swings) and an anxiety disorder (a mental health condition characterized by excessive and persistent fear or worry impacting daily life). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/13/2025, the MDS indicated Resident 2 had moderate cognitive (ability to think and reason) impairment and a history of delusions (having false or unrealistic beliefs).The MDS indicated Resident 2 had a history of physical behaviors directed toward others, verbal behaviors directed toward others, and other behavioral symptoms which put others at significant risk for physical injury and significantly intruded on the privacy or activity of others. The MDS indicated Resident 2 was able to express ideas and wants and was able to understand others During a review of Resident 2's Care Plan, dated 2/2/2024, the Care Plan indicated Resident 2 wanders inside the building in his wheelchair, related to impaired cognition, poor judgment, new admission, and a change in environment. The Care Plan's goal indicated Resident 2 would remain safe within the facility times 90 days. The Care Plan interventions indicated Resident 2 would have a 1:1 sitter. During a review of Resident 2's Physician Order Summary dated 6/7/2024, the Physician's Order Summary indicated Resident 2 would have a 1:1 sitter related to Resident 2's wandering and invading other resident's privacy. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on 3/27/2025, at 10:30 a.m., Resident 1's Responsible Party (RP1), stated on approximately 2/25/2025, a man entered Resident 1's room's and tried to take her cell phone. RP 1 stated Resident 1 screamed for help and the man left the room. RP 1 stated Resident 1 felt scared, angry, and violated, that a man entered her room without her permission and tried to take her cell phone. During an interview on 3/28/2025, at 12:30 p.m., the Director of Nursing (DON) stated on 2/25/2025 (time unknown)she heard Resident 1 yell, help me. The DON stated when she went to Resident 1's room she saw Resident 1 in bed with her cell phone in her hand and Resident 2 sitting in his wheelchair at the foot of Resident 1's bed. The DON stated Resident 1 looked upset and reported that Resident 2 tried to take her cell phone. The DON stated Resident 2's care plan indicated Resident 2 was to have a 1:1 sitter at all times. The DON stated Resident 2 was assigned a 1:1 sitter and should not have been in Resident 1's room. The DON stated after reviewing the facility's Staff Assignment sheet, that she (the DON) could not determine who was assigned to Resident 1 as his sitter During a review of the facility's Policy and Procedure (P/P) titled, Care Plan Comprehensive dated 8/25/2021, the P&P indicated the facility's interdisciplinary team ([IDT] a team of health care workers from different specialties working together to meet the residents' care needs/goals) in coordination with the resident and or his family or representative must develop and implement a comprehensive person-centered plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, physical and mental and psychosocial needs that are identified in the comprehensive assessment. The P/P indicated the comprehensive care plan includes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2), who had a history of wandering into other residents' rooms, and who had an order for a one to one (1:1) sitter (a healthcare worker who provides constant, continuous observation to a single resident to ensure their safety and prevention potential harm), was supervised to prevent him from entering the room of another resident (Resident 1) . This deficient practice resulted in Resident 2 entering Resident 1's room on 2/25/2025 without Resident 1's consent or facility staff's knowledge and attempting to take Resident 1 ' s cell phone. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (amental disease that is characterized by disturbances in thought), a mood disorder (amental health condition that affects a person's emotional state involving extreme mood swings) and ananxiety disorder (amental health condition characterized by excessive and persistent fear or worry impacting daily life). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 2/13/2025, the MDS indicated Resident 2 had moderate cognitive (ability to think and reason) impairment and a history of delusions (having false or unrealistic beliefs).The MDS indicated Resident 2 had a history of physical behaviors directed toward others, verbal behaviors directed toward others, and other behavioral symptoms which put others at significant risk for physical injury and significantly intruded on the privacy or activity of others. The MDS indicated Resident 2 was able to express ideas and wants and wasable to understand others. During a review of Resident 2's Care Plan, dated 2/2/2024, the Care Plan indicated Resident 2 wanders inside the building in his wheelchair, related to impaired cognition, poor judgment, new admission, and a change in environment. The Care Plan'sgoal indicatedResident 2 wouldremain safe within the facility times90 days. The Care Plan interventions indicated Resident 2 would have a 1:1 sitter. During a review of Resident 2's Physician Order Summary dated 6/7/2024, the Physician's Order Summary indicated Resident 2 would have a 1:1 sitter related to Resident 2's wandering andinvading other resident's privacy. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of generalized muscle weakness. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was able to make independent decisions that were consistent and reasonable. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on 3/27/2025, at 10:30 a.m., Resident 1's Responsible Party (RP1), stated on approximately 2/25/2025, a man entered Resident 1's room's and tried to take her cell phone. RP 1 stated Resident 1 screamed for help and the man left the room. RP 1 stated Resident 1 felt scared, angry, and violated, that a man entered her room without her permission and tried to take her cell phone. During an interview on 3/28/2025, at 12:30 p.m., the Director of Nursing (DON) stated on 2/25/2025 (unknown time), he heardResident 1 yell,help me. The DON stated when he went to Resident 1's room hesaw Resident 1 in bed with her cell phone in her hand and Resident 2 sitting in his wheelchair at the foot of Resident 1's bed. The DON stated Resident 1 looked upset and reported that Resident 2 tried to take her cell phone. The DON stated Resident 2's care plan and physician's order indicated Resident 2 was to have a 1:1 sitter at all times. The DON stated Resident 2 was assigned a 1:1 sitter and he should not have been in Resident 1's room. The DON stated after reviewing the facility's Staff Assignment sheet, that she (the DON) could not determine who was assigned to Resident 1 as his sitter. The DON stated Resident 1's privacy was violated when Resident 2 entered Resident 1's room and attempted to take her cell phone. During a review of the facility's Policy and Procedure (P/P) titled, Safety for Residents dated 6/27/2022, the P&P indicated the purpose of the policy is to provide a safe environment for residents and Facility Staff. The P/P indicated in response to unsafe behavior, the facility will maintain one to one supervision of resident until the behavior has subsided.