

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Bay Crest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777</b></p> <p>Based on observation, interview, and record review the facility failed to ensure one out of three residents (Resident 2) was free from medication error when :</p> <p>Resident 2 received 2 doses of Temazepam (medication used to treat inability to sleep) 15 mg( milligrams- a unit of mass or weight).</p> <p>This deficient practice had the potential for Resident 2 to have difficulty in staying awake, slowed breathing , loss of consciousness , coma and potentially death.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease stage 3 ( where the kidneys struggle to filter waste and fluid effectively ) , essential (primary) hypertension ( high blood pressure) and muscle weakness .</p> <p>During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 2 /24 /2025, the MDS indicated Resident 2 ' s cognition was intact. The MDS indicated Resident 2 requires partial/moderate assistance ( Helper lifts, holds or supports trunk or limbs, but provides less than half the effort ) with toileting hygiene, shower/bath self, lower body dressing and putting on/ taking off footwear.</p> <p>During a record review of Resident 2 ' s Order Summary Report (OSR), indicates a start date or 5/7/2025 for temazepam capsule 15 mg give 1 capsule by mouth every 24 as needed for insomnia (inability to sleep ) manifested by inability to sleep.</p> <p>During record review and interview on 5/14/2025 at 12:00 p.m., with Licensed Vocational Nurse 2 (LVN 2) , LVN 2 stated on 5/12/2026 at 22:36p.m., she gave Resident 2 temazepam 15 mg 1 capsule by mouth after he complained of inability to sleep.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 5/14/2025 at 12:30 p.m., with LVN 1, LVN 1 stated on 5/13/2025 at 01:00 a. m., she gave Resident 2 temazepam 15 mg capsule by mouth when he complained he could not sleep. LVN 1 stated she asked Resident 1 if he received medication for sleep prior to her giving a dose and Resident 1 stated no. LVN 1 stated she pulled the temazepam 15 mg capsule, gave the medication to the resident and signed the Antibiotic or Controlled Drug Record LVN 1 stated she went to chart the medication into the Point Click Care ( electronic charting) and was not able to because the point click care alerted her the time from the last temazepam 15 mg was too close to administer. LVN 1 stated this is when she noticed Resident 2 had a 15 mg dose of temazepam two hours and 24 minutes ago before that .</p> <p>LVN 1 stated the correct process of giving controlled medication is to do a resident assessment in the point click care. The point click care will then alert you indicating the medication time to give temazepam is ok to give to the resident or the time when you can give the next dose. LVN stated you will pull the medication and administer to the resident , sign the PCC first and then sign the Antibiotic or Controlled Record .</p> <p>During a record review and interview on 5/14/2025 at 1:57 p.m., with the Director of Nursing (DON) , DON stated when giving a controlled medication the nurse is to check the PCC first because it is timed and prevents medication errors.</p> <p>During a review of the facility's undated policy titled Administering Medications, revised April 2019, the P&amp;P indicates medications are administered in a safe and timely manner and as prescribed.</p> <p>Medications are administered in accordance with prescribers ' orders, including any required time frame</p> <p>Based on observation, interview, and record review the facility failed to ensure one out of three residents (Resident 2) was free from medication error when :</p> <p>Resident 2 received 2 doses of Temazepam (medication used to treat inability to sleep) 15 mg( milligrams- a unit of mass or weight).</p> <p>This deficient practice had the potential for Resident 2 to have difficulty in staying awake, slowed breathing , loss of consciousness , coma and potentially death.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic kidney disease stage 3 ( where the kidneys struggle to filter waste and fluid effectively ), essential (primary) hypertension ( high blood pressure) and muscle weakness .</p> <p>During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 2 /24 /2025, the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 requires partial/moderate assistance ( Helper lifts, holds or supports trunk or limbs, but provides less than half the effort ) with toileting hygiene, shower/bath self, lower body dressing and putting on/ taking off footwear.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 2's Order Summary Report (OSR), indicates a start date of 5/7/2025 for temazepam capsule 15 mg give 1 capsule by mouth every 24 as needed for insomnia (inability to sleep ) manifested by inability to sleep.</p> <p>During record review and interview on 5/14/2025 at 12:00 p.m., with Licensed Vocational Nurse 2 (LVN 2) , LVN 2 stated on 5/12/2026 at 22:36p.m., she gave Resident 2 temazepam 15 mg 1 capsule by mouth after he complained of inability to sleep.</p> <p>During a telephone interview on 5/14/2025 at 12:30 p.m., with LVN 1, LVN 1 stated on 5/13/2025 at 01:00 a. m., she gave Resident 2 temazepam 15 mg capsule by mouth when he complained he could not sleep. LVN 1 stated she asked Resident 1 if he received medication for sleep prior to her giving a dose and Resident 1 stated no. LVN 1 stated she pulled the temazepam 15 mg capsule, gave the medication to the resident and signed the Antibiotic or Controlled Drug Record LVN 1 stated she went to chart the medication into the Point Click Care ( electronic charting) and was not able to because the point click care alerted her the time from the last temazepam 15 mg was too close to administer. LVN 1 stated this is when she noticed Resident 2 had a 15 mg dose of temazepam two hours and 24 minutes ago before that .</p> <p>LVN 1 stated the correct process of giving controlled medication is to do a resident assessment in the point click care. The point click care will then alert you indicating the medication time to give temazepam is ok to give to the resident or the time when you can give the next dose. LVN stated you will pull the medication and administer to the resident , sign the PCC first and then sign the Antibiotic or Controlled Record .</p> <p>During a record review and interview on 5/14/2025 at 1:57 p.m., with the Director of Nursing (DON) , DON stated when giving a controlled medication the nurse is to check the PCC first because it is timed and prevents medication errors.</p> <p>During a review of the facility's undated policy titled Administering Medications, revised April 2019, the P&amp;P indicates medications are administered in a safe and timely manner and as prescribed.</p> <p>Medications are administered in accordance with prescribers' orders, including any required time frame.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777</b></p> <p>Based on observation, interview, and record review the facility failed to accurately document the administration of temazepam (medication for sleep )15 milligrams (mg unit of measure) for one out of three resident ' s (Resident 2) when :</p> <p>Facility staff failed to document the accurate date temazepam 15 mg was administered on Controlled Drug Record (CDR) for Resident 2.</p> <p>This deficient practice had the potential to compromise Resident 2 ' s safety by administering medications at the wrong time, causing a missed dose, and or receiving duplicate administrations.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease stage 3 ( where the kidneys struggle to filter waste and fluid effectively ), essential (primary) hypertension ( high blood pressure) and muscle weakness.</p> <p>During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 2/24 2025, the MDS indicated Resident 2 ' s cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 2 requires partial/moderate assistance ( Helper lifts, holds or supports trunk or limbs, but provides less than half the effort ) with toileting hygiene, shower/bath self, lower body dressing and putting on/ taking off footwear.</p> <p>During a record review of Resident 2 ' s Order Summary Report (OSR), the Order Summary Report indicated a start date of 5/7/2025 for temazepam capsule 15 mg, give 1 capsule by mouth every 24 hours as needed for insomnia (inability to sleep ) manifested by inability to sleep.</p> <p>During record review and interview on 5/14/2025 at 12:00 p.m., with Licensed Vocational Nurse 2 (LVN 2) , LVN 2 stated on 5/12/2025 at 10:36 p.m., she administered temazepam 15 mg to Resident 2 by mouth after he complained of an inability to sleep. LVN 2 stated she charted the date of administration as 5/11/2025 on the CDR instead of the correct date of 5/12/2025 (the actual day it was administered). LVN 2 stated it was important to double-check your documentation, because not documenting the correct date can be deceiving to the next nurse and lead to errors.</p> <p>During an interview on 5/14/2025 at 1:57 p.m., with the Director of Nursing (DON), the DON stated most narcotics (Sedative-hypnotic drug products including drugs used to induce and/or maintain sleep) are given when necessary and you do not want to give them too close together. The DON stated the correct date, and time needs to be entered on the Controlled Drug Record this can prevent drug overdoses.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Controlled Medications the P&amp;P indicated when a controlled medication is administered , the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR):</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1.Date and time of administration.</p> <p>2.Amount administered.</p> <p>3. Signature of the nurses administering the dose on accountability record at the time the medication is removed from the supply.</p> <p>4 initials of nurse administering the dose on the MAR after the medication is administered</p> <p>Based on observation, interview, and record review the facility failed to accurately document the administration of temazepam (medication for sleep )15 milligrams (mg unit of measure) for one out of three resident's (Resident 2) when :</p> <p>Facility staff failed to document the accurate date temazepam 15 mg was administered on Controlled Drug Record (CDR) for Resident 2.</p> <p>This deficient practice had the potential to compromise Resident 2's safety by administering medications at the wrong time, causing a missed dose, and or receiving duplicate administrations.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease stage 3 ( where the kidneys struggle to filter waste and fluid effectively ), essential (primary) hypertension ( high blood pressure) and muscle weakness .</p> <p>During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 2/24 2025, the MDS indicated Resident 2's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 2 requires partial/moderate assistance ( Helper lifts, holds or supports trunk or limbs, but provides less than half the effort ) with toileting hygiene, shower/bath self, lower body dressing and putting on/ taking off footwear.</p> <p>During a record review of Resident 2's Order Summary Report (OSR), the Order Summary Report indicated a start date of 5/7/2025 for temazepam capsule 15 mg, give 1 capsule by mouth every 24 hours as needed for insomnia (inability to sleep ) manifested by inability to sleep.</p> <p>During record review and interview on 5/14/2025 at 12:00 p.m., with Licensed Vocational Nurse 2 (LVN 2) , LVN 2 stated on 5/12/2025 at 10:36 p.m., she administered temazepam 15 mg to Resident 2 by mouth after he complained of an inability to sleep. LVN 2 stated she charted the date of administration as 5/11/2025 on the CDR instead of the correct date of 5/12/2025 (the actual day it was administered). LVN 2 stated it was important to double-check your documentation, because not documenting the correct date can be deceiving to the next nurse and lead to errors.</p> <p>During an interview on 5/14/2025 at 1:57 p.m., with the Director of Nursing (DON), the DON stated most narcotics (Sedative-hypnotic drug products including drugs used to induce and/or maintain sleep) are given when necessary and you do not want to give them too close together. The DON stated the correct date, and time needs to be entered on the Controlled Drug Record this can prevent drug overdoses.</p> <p>(continued on next page)</p>

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