

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 06/03/2025
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sample residents (Resident 1) who received enteral (a method of providing nutrition directly into the stomach, either through the mouth or via a feeding tube that goes directly into the stomach or small intestine) feeding via a Gastrostomy ([G-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, common for people with swallowing problems) and had a history of pulling and dislodging (to forcefully remove) her G-Tube, Licensed Vocational Nurse (LVN) 1 assessed and checked placement of Resident 1 ' s G-tube site every four hours on 6/25/2025 per the facility ' s Policy and Procedure (P&P) titled, Enteral Feedings.</p> <p>These deficient practices resulted in LVN 1 not assessing or checking Resident 1 ' s G-tube placement upon the start of her shift and every four hours which resulted in Resident 1 ' s G-tube being dislodged. These deficient practices had the potential for Resident 1 to experience pain and trauma resulting from the accidental removal of the G-tube from the Gastrostomy site.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), severe protein calorie malnutrition (not getting enough nutrients), anorexia (eating disorder causing low body weight) and G-Tube.</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 5/9/2025, the MDS indicated Resident 1 ' s cognition (ability to register and recall information) was impaired. The MDS indicated Resident 1 was fully dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for all Activities of Daily Living ([ADLs]. The MDS further indicated Resident 1 required enteral feedings via G-Tube during the assessment period.</p> <p>During a review of Resident 1 ' s History and Physical (H&P), dated 5/14/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Order Summary Report (Physician ' s Orders) dated 2/2025, the orders indicated Resident 1 was to receive enteral feeding of Jevity (enteral feeding formula) 1.5 calories every shift, to run at 55 milliliters ([mL] unit of measurement) per hour via pump, for 12 hours or until dose is completed, ordered on 2/18/2025.</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Change of Condition (COC) form, dated 3/3/2025, the COC indicated on 3/3/2025 at approximately 7 a.m., Resident 1 ' s G-tube was observed to be dislodged.</p> <p>During a review of Resident 1's Physician ' s Orders dated 5/2025, the orders indicated Resident 1 was to receive enteral feeding of Jevity 1.5 calories every shift, to run at 50 mL via pump, for 12 hours or until dose is completed, ordered on 5/8/2025.</p> <p>During a review of Resident 1's Interdisciplinary ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Care Conference Notes, dated 5/19/2025, the IDT Note indicated Resident 1 continued to demonstrate signs of agitation and would tug on her G-Tube. The IDT Note indicated Resident 1 ' s Responsible Party (RP) 1 preferred Resident 1 to be dressed in long dresses to prevent Resident 1 from pulling the G-Tube out.</p> <p>During a review of Resident 1's COC form, dated 5/25/2025, the COC indicated as Resident 1 was getting changed (receiving ADL care) for the day, CNA 1 noticed Resident 1 ' s G-tube was dislodged and notified LVN 1. LVN 1 confirmed the G-tube was dislodged and notified the physician and RP 1.</p> <p>During an interview on 6/3/2025 at 9 a.m., Resident 1 ' s Responsible Party (RP 1) stated when arrived to visit Resident 1 on 5/25/2025, LVN 1 notified him that Resident 1 had pulled out her G-Tube. RP 1 stated this was not the first time Resident 1 had pulled out her G-Tube. RP 1 stated, during the last IDT meeting, he asked the staff to make sure Resident 1 is frequently checked on because she will pull at her G-Tube. RP 1 stated Resident 1 required an emergency room visit on 5/25/2025, to reinsert the G-Tube. RP 1 stated he witnessed his mother sustain a great deal of discomfort and pain during the reinsertion of the G-Tube. RP 1 stated he felt angry and frustrated at the staff for neglecting to assess and monitor his mother.</p> <p>During a telephone interview on 6/3/2025 at 2 p.m., Certified Nurse Assistant (CNA) 1 stated upon the start of her shift on 5/25/2025 at 7 a.m., she I did not provide Resident 1 with ADL care because Resident 1 was sleeping. CNA 1 stated she did not observe if the G-Tube was dislodged because Resident 1 had the abdominal binder (compression belt that encircles the abdomen) on. CNA 1 stated at approximately 9 a.m., Resident 1 appeared restless and pointed to her stomach and told me her stomach hurt, I unfastened the abdominal binder, and I saw that the G-Tube was no longer inserted and was dislodged. CNA 1 stated she immediately notified LVN 1.</p> <p>During a telephone interview on 6/3/2025 at 2:30 p.m., LVN 1 stated Resident 1 ' s typical behavior was to attempt to pull out her G-Tube. LVN 1 stated upon the start of her shift on 5/25/2025 at 7 a.m., she I did not assess Resident 1 ' s G-Tube site nor check for placement because Resident 1 was sleeping. LVN 1 stated she observed Resident 1 ' s enteral feeding pump to be infusing and observed Resident 1 was wearing an abdominal binder covering the G-Tube site. LVN 1 stated she did not assess Resident 1 ' s G-Tube site until approximately 9:40 a.m. when CNA 1 notified her that Resident 1 ' s G-Tube was dislodged. LVN 1 stated she should have assessed and checked placement of Resident 1 ' s G-Tube during her initial rounds when she arrived at 7 a.m. LVN 1 stated failure to assess the G-Tube site timely caused a delay in care and services because it is unknown how long Resident 1 ' s G-Tube was dislodged. LVN 1 stated this put Resident 1 at risk for potential injury due to the trauma of the dislodgement.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/3/2025 at 2:45 p.m., RN 1 stated on 5/25/2025 at approximately 4:30 a.m., she assessed Resident 1 and found Resident 1 ' s enteral feeds were infusing. RN 1 stated she did not check on or reassess Resident 1 ' s G-Tube site prior to the end of her shift at 7 a.m. RN 1 stated she was aware of Resident 1 ' s behaviors of attempting to pull at her (Resident 1 ' s) G-Tube but because Resident 1 was asleep and the abdominal binder was in place, she (RN 1) assumed the G-Tube was still in place. RN 1 stated she could not ensure Resident 1 ' s G-Tube was still in place at 7 a.m. on 5/25/2025 when she left for the day because she did not check on Resident 1 after 4:30 a.m.</p> <p>During an interview on 6/3/2025 at 4 p.m., the Director of Nursing (DON) stated Resident 1 frequently attempts to pull on her G-Tube and it is important for the nursing staff to access her G-Tube site frequently. The DON stated LVN 1 should have accessed and checked placement of Resident 1 ' s G-Tube to ensure the site was free of complication such as redness, swelling and placement. The DON stated by LVN 1 not completing an appropriate assessment which included checking the placement of Resident 1 ' s G-Tube, it led to delay in care and treatment for Resident 1 needing replacement of the G-Tube.</p> <p>During a review of the facility ' s P&P, titled, Enteral Feedings, revised 2018, the P&P indicated the facility will ensure safe administration of enteral nutrition and the facility will remain current in and follow accepted best practices in enteral nutrition. The P&P indicated staff will check enteral tube placement every four hours and prior to feeing or administration of medication, assess gastrostomy frequently and then with each feeding or medication administration.</p>		