

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 10/15/2025
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to separate, supervise and monitor one of three sampled residents (Resident 1), when on 10/7/2025 at approximately 9:30 p.m., Certified Nurse Assistant (CNA) 2 and Licensed Vocational Nurse (LVN) 1, were informed by Resident 1 that Resident 2, who had a history delusions (unrealistic false or unrealistic beliefs) and wandering into her (Resident 2) roommate's living spaces, yelled at her, threw water on her and hit her with a water bottle. This deficient practice resulted in Resident 1 feeling unsafe and fearful of being attacked by Resident 2 and placed Resident 1 at risk for continued verbal and physical abuse. 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 dementia (a progressive state of decline in mental abilities), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 10/6/2025, the MDS indicated Resident 2 had severe cognitive (ability to think and reason) impairment and was rarely or never understood. The MDS indicated Resident 2 had a history of delusions and physical behaviors (ex: hitting) directed toward others, verbal behaviors (threatening and screaming) directed toward others, and other behavioral symptoms which put others at significant risk for physical injury and other behaviors not directed toward others (ex: pacing and rummaging, verbal/vocal sounds like screaming, disruptive sounds). During a review of Resident 2's Care Plan, dated 9/24/2025, the Care Plan indicated Resident 2 was at risk for elopement due to wandering aimlessly. The care plan's interventions indicated to assist Resident 2 to supervised areas, and to monitor Resident 2's whereabouts.During a review of the Police Department's General Case Report, dated 10/9/2025, the General Case Report indicated Resident 1 reported that on approximately 10/6/2025 or 10/7/2025 in the evening, she was lying in bed when she was approached by her roommate (Resident 2) who stood directly in front of her face. The General Case Report indicated Resident 2 grabbed a plastic water bottle and struck Resident 1 on her feet and shin (front of the leg below the knee) approximately five to ten times. The General Case Report indicated Resident 1 told Resident 2 to stop and yelled to get someone's attention. During an interview on 10/9/2025, at 12:20 p.m., Resident 1 stated on approximately 10/7/2025 sometime in the evening, Resident 2 approached her while she (Resident 1) was lying in bed and hit her on the leg with a water bottle. Resident 1 stated she told Resident 2 to stop but Resident 2 would not listen. Resident 1 stated she yelled for help and pressed the call light, but no one arrived. Resident 1 stated Resident 2 often invades her personal space, pulls open her privacy curtain and takes her personal items. Resident 1 stated she has told the nursing staff in the past, but nothing was done about it. Resident 1 stated her Responsible Party (RP) 1 called the police and they came to investigate because the facility was not doing anything to prevent Resident 2 from invading her space. Resident 1 stated she was afraid that Resident 2 would try to hurt her again until she (Resident 2) was finally transferred out of their room. During an interview on 10/10/2025, at 8:30 a.m., Resident 3 stated on 10/7/2025 sometime in the evening, Resident 2 walked past her (Resident 3) personal living space, entered Resident 1's living space, and proceeded to yell at Resident 1. Resident 3 stated Resident 2 was confused and often wandered in her (Resident 3) and Resident's space. Resident 3 stated she often worried that she would wake up and Resident 2 would be standing over her bed or she would punch her in her face. During telephone interview on 10/10/2025, at 2:30 p.m., CNA 2 stated on 10/7/2025 at approximately 9:45 p.m., she heard a loud noise and yelling coming from Resident 1 and Resident 2's shared room. CNA 2 stated when she entered the room she observed Resident 2 standing very close to Resident 1. CNA 2 stated Resident 1 appeared very agitated/upset and was saying that Resident 2 was in her space, throwing and hitting her with a water bottle. CNA 2 stated she observed a water pitcher on the ground near Resident 1's bed. CNA 2 stated Resident 2 would not leave Resident 1's personal area and required continued redirection. CNA 2 stated LVN 1 entered the room and aided in redirecting Resident 2 back to her area of the room. During telephone interview on 10/14/2025, at 8:30 a.m., Resident 1's Responsible Party (RP) 1 stated on 10/7/2025 at approximately 9:30 p.m., she received a call from Resident 1 reporting that Resident 2 was in her personal living area, yelling at her and hitting her with an object. RP 1 stated she could hear yelling and screaming on the phone. RP 1 stated she was concerned about Resident 1's safety and called the police to perform a wellness check on Resident 1. During interview on 10/14/2025 at 3:30 p.m. LVN 1 stated when she entered Resident 1 and Resident 2's shared room</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) within two hours of the incident by one of three sampled residents (Resident 2). On 10/7/2025 at approximately 9:30 p.m., Certified Nurse Assistant (CNA) 2 and Licensed Vocational Nurse (LVN) 1, were informed by Resident 1 that Resident 2 came to her bedside, yelled at her, threw water on her and hit her with an object. This deficient practice resulted in CDPH being unaware of the abuse incident and injury to Resident 1 and had the potential for a delay in CDPH's investigation and other abuse allegations to go unreported. 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 dementia (a progressive state of decline in mental abilities), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 10/6/2025, the MDS indicated Resident 2 had severe cognitive (ability to think and reason) impairment and was rarely or never understood. The MDS indicated Resident 2 had a history of delusions and physical behaviors (ex: hitting) directed toward others, verbal behaviors (threatening and screaming) directed toward others, and other behavioral symptoms which put others at significant risk for physical injury and other behaviors not directed toward others (ex: pacing and rummaging, verbal/vocal sounds like screaming, disruptive sounds). During a review of the Police Department's General Case Report, dated 10/9/2025, the General Case Report indicated Resident 1 reported that on approximately 10/6/2025 or 10/7/2025 in the evening, she was lying in bed when she was approached by her roommate (Resident 2) who stood directly in front of her face. The General Case Report indicated Resident 2 grabbed a plastic water bottle and struck Resident 1 on her feet and shin (front of the leg below the knee) approximately five to ten times. The General Case Report indicated Resident 1 told Resident 2 to stop and yelled to get someone's attention. During an interview on 10/9/2025, at 12:20 p.m., Resident 1 stated on approximately 10/7/2025 sometime in the evening, Resident 2 approached her while she (Resident 1) was lying in bed and hit her on the leg with a water bottle. Resident 1 stated she told Resident 2 to stop but Resident 2 would not listen. Resident 1 stated she yelled for help and pressed the call light, but no one arrived. Resident 1 stated Resident 2 often invades her personal space, pulls open her privacy curtain and takes her personal items. Resident 1 stated she told the nursing staff in the past, but nothing was done about it. During telephone interview on 10/10/2025, at 2:30 p.m., CNA 2 stated on 10/7/2025 at approximately 9:45 p.m., she heard a loud noise and yelling coming from Resident 1 and Resident 2's shared room. CNA 2 stated when she entered the room she observed Resident 2 standing very close to Resident 1. CNA 2 stated Resident 1 appeared very agitated/upset and was saying that Resident 2 was in her space, throwing and hitting her with a water bottle. CNA 2 stated she observed a water pitcher on the ground near Resident 1's bed. CNA 2 stated Resident 2 would not leave Resident 1's personal area and required continued redirection. CNA 2 stated LVN 1 entered the room and aided in redirecting Resident 2 back to her area of the room. but she did not report the incident to because no one was hurt and she thought the Administrator (ADM) already knew what was going on between Resident 1 and Resident 2. During telephone interview on 10/14/2025, at 8:30 a.m., Resident 1's Responsible Party (RP) 1 stated on 10/7/2025 at approximately 9:30 p.m., she received a call from Resident 1 reporting that Resident 2 was in her personal living area, yelling at her and hitting her with an object. RP 1 stated she could hear yelling and screaming on the phone. RP 1 stated she was concerned about Resident 1's safety and called the police to perform a wellness check on Resident 1. During an interview on 10/14/2025, at 4 p.m., the Director of Nursing (DON) he overheard about the incident between Resident 1 and Resident 2 on 10/8/2025 during a staff huddle. The DON stated LVN 1 should have reported the allegation of abuse to the ADM on 10/7/2025 when she was made aware by Resident 1 that Resident 2 hit her with a water bottle. The DON stated all allegations, and suspected abuse should be reported to the ADM, the police, Ombudsman and CDPH immediately and within two hours. The DON stated failure to report abuse placed Resident 1 at risk for continued abuse, caused a delay and or lack of needed services to Resident 1 and Resident 2, led to a delay in CDPH's investigation, and was a violation of the Federal regulations. During an interview on 10/14/2025 at 4:15 p.m., the ADM stated she was in the building on 10/7/2025 until almost 11 p.m. but was not informed of the incident Resident 1 and Resident 2 until it was reported to her by the DON on 10/8/2025. The ADM stated once it</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and a care plan with goals and interventions for one of four sampled residents (Resident 2), who had a history of delusions (unrealistic false or unrealistic beliefs), and wandering into her roommate's (Resident 1 and Resident 3) living space (a personal area belonging to each resident in a shared room) and was assessed with physical behaviors of hitting, and verbal behaviors of threatening and screaming. This deficient practice resulted in Resident 2 entering Resident 1's personal living area on 10/7/2025 without the consent of Resident 1 and unbeknownst to facility staff, Resident 1 feeling violated and threatened by Resident 2 invading her personal space, and an allegation of bodily harm inflicted by Resident 2 toward Resident 1. 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 dementia (a progressive state of decline in mental abilities), and major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 10/6/2025, the MDS indicated Resident 2 had severe cognitive (ability to think and reason) impairment and was rarely or never understood. The MDS indicated Resident 2 had a history of delusions and physical behaviors (ex: hitting) directed toward others, verbal behaviors (threatening and screaming) directed toward others, and other behavioral symptoms which put others at significant risk for physical injury and other behaviors not directed toward others (ex: pacing and rummaging, verbal/vocal sounds like screaming, disruptive sounds). During a review of Resident 2's Care Plan, dated 9/24/2025, the Care Plan indicated Resident 2 was at risk for elopement due to wandering aimlessly. The care plan's interventions indicated to assist Resident 2 to supervised areas, and to monitor Resident 2's whereabouts. Continued review of Resident 2's Care Plan did not indicate/include Resident 2's behavior of wandering into other residents rooms, touching/taking their personal items or other acts of aggression with interventions to contain her behavior. During an interview on 10/9/2025, at 12:20 p.m., Resident 1 stated on approximately 10/7/2025 sometime in the evening, Resident 2 approached her while she (Resident 1) was lying in bed and hit her on the leg with a water bottle. Resident 1 stated she told Resident 2 to stop but Resident 2 would not listen. Resident 1 stated she yelled for help and pressed the call light, but no one arrived. Resident 1 stated Resident 2 often invades her personal space, pulls open her privacy curtain and takes her personal items. Resident 1 stated she has told the nursing staff in the past, but nothing was done about it. Resident 1 stated her Responsible Party (RP) 1 called the police and they came to investigate because the facility was not doing anything to prevent Resident 2 from invading her space. Resident 1 stated she was afraid that Resident 2 would try to hurt her again until she (Resident 2) was finally transferred out of their room. During telephone interview on 10/10/2025, at 2:30 p.m., CNA 2 stated on 10/7/2025 at approximately 9:45 p.m., she heard a loud noise and yelling coming from Resident 1 and Resident 2's shared room. CNA 2 stated when she entered the room she observed Resident 2 standing very close to Resident 1. CNA 2 stated Resident 1 appeared very agitated/upset and was saying that Resident 2 was in her space, throwing and hitting her with a water bottle. CNA 2 stated Resident 2 would not leave Resident 1's personal area and required continued redirection. CNA 2 stated LVN 1 entered the room and aided in redirecting Resident 2 back to her area of the room. During an interview on 10/14/2025, at 8:20 a.m., Resident 4 stated she previously had shared a room with Resident 2. Resident 4 stated Resident 2 was transferred out of their room (date unknown) because Resident 2 would pull open her (Resident 4) and another roommate's (Resident 5) privacy curtains and stare at at them (Resident 4 and Resident 5) and take her (Resident 4) personal belongings without permission, making them feel uncomfortable and violated. Resident 4 stated she reported the incident to the Administrator (ADM) and facility staff but nothing was done to prevent Resident 2's behavior. Resident 4 stated sometime during 9/2025, she called staff for help because Resident 2 would not leave Resident 5's living space. Resident 4 stated it took CNA 1 and a second staff (unknown) to redirect Resident 2 back to her side of the room. Resident 4 state she felt anxious (experiencing worry, unease, or nervousness, typically about an imminent event or something with an uncertain outcome) and violated due to Resident 2's continued behavior. Resident 4 stated Resident 2 was very confused and did not understand the meaning of no. During telephone interview on 10/14/2025, at 8:30 a.m., Resident 1's Responsible Party (RP) 1 stated on 10/7/2025 at approximately 9:30 p.m., she received a call from Resident 1 reporting that Resident 2 was in her personal living area, yelling at her and hitting her</p>		