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	11/09/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure admission orders were entered and implemented in a timely manner for one of three sampled residents (Resident 1) upon admission on [DATE] at approximately 9:00 p.m. The facility failed to:1. Initiate or carry out Resident 1's physician orders on the day of admission, despite the resident having multiple serious medical conditions. Licensed staff were unaware of Resident 1's presence in the facility for over two hours, and no admission packet or orders were available or processed during that time. This deficient practice placed Resident 1 at significant risk for harm, including potential neglect and unmet medical needs.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted from GACH 1 to the facility on [DATE] with the diagnosis including acute myocardial infraction (MI-heart attack), presence of coronary angioplasty implant and graft (minimally invasive procedure used to open narrowed or blocked coronary [arteries which surround and supply the heart] arteries), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) chronic obstructive pulmonary disease (COPD-lung disease) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During an interview on 11/07/2025 at 8:45 a.m., Resident 2, who shared a room with Resident 1, stated that Resident 1 arrived at their shared room around 9:00 p.m. on 11/03/2025.During an interview on 11/07/2025 at 11:18 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that she was unaware Resident 1 had been admitted to the facility until she observed him in bed during her rounds at approximately 11:30 p.m. on 11/03/2025. LVN 4 stated that she had not received a report on Resident 1 and that there was no admission packet or hospital orders available. LVN 4 stated she did not enter any admission orders into the electronic system. LVN 4 stated that she should have been informed of Resident 1's needs prior to providing care and expressed concern that not knowing the resident's name or medical conditions posed a risk for neglect.During an interview on 11/08/2025 at 8:22 a.m., with Registered Nurse Supervisor 2 (RNS2), RNS 2 stated that a recurring issue with admissions was that they often occur during the 3:00 p.m. to 11:00 p. m. shift, when there was no RNS to oversee the admission process. RNS 2 stated that admission orders should be initiated immediately upon the residents' arrival to ensure appropriate and timely care.During an interview on 11/09/2025 at 12:27 p.m., with the Administrator (ADM), the ADM stated that admission orders were expected to be initiated within 30 minutes of a resident's arrival. The ADM stated the failure to initiate timely orders as a horrible [NAME] effect that compromises resident safety and acknowledged that the facility failed to follow protocol. During a review of the facility's policy and procedure (P&P) titled, admission Assessment and Follow Up: Role of the Nurse dated 9/2012, the P&P indicated The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. Notify the supervisor and the Attending Physician of immediate needs that the resident may have.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was accurately assessed for the risk of elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision).This deficient practice resulted in an inaccurate assessment of Resident 1's risk for elopement and the facility's failure to develop and implement a care plan with appropriate interventions to prevent potential elopement.Findings:During a review of GACH 1's Physical Therapy (PT (licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) assessment dated [DATE], the PT assessment indicated Resident 1 was alert, able to ambulate 10 feet (ft-unit of measure) with a FWW. The PT Assessment indicated Resident 1's gait (walking) was slow, and Resident 1 complained of fatigue (lack of energy). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted from GACH 1 to the facility on [DATE] with the diagnosis including acute myocardial infraction (MI-heart attack), presence of coronary angioplasty implant and graft (minimally invasive procedure used to open narrowed or blocked coronary [arteries which surround and supply the heart] arteries), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) chronic obstructive pulmonary disease (COPD-lung disease) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Joint Mobility Screening (a series of tests to assess a person's joint health and flexibility) dated 11/04/2025 , the Joint Mobility Screening indicated Resident 1 had full range of motion (FROM- performing an exercise without limitations) to bilateral (both) upper extremities (BUE-right and left arm) and bilateral lower extremities (BLE - right and left leg).During a review of Resident1's Elopement Risk Assessment, dated 11/04/2025, the Elopement Risk Assessment indicated Resident 1 could not walk or self-propel wheelchair independently. During a concurrent interview and record review on 11/7/2025 at 12:03 p.m. with the Physical Therapy Director (PTD), Resident1's Joint Mobility Screening dated 11/04/2025 was reviewed. The PTD stated she had completed the assessment and stated Resident 1 demonstrated full range of motion in both upper and lower extremities. PTD stated Resident 1 was able to walk to the bathroom using a FWW with minimal assistance but required frequent safety cues due to being impulsive while walking.During a concurrent interview and record review on 11/7/2025 at 1:59 p.m. with RNS 1, Resident 1's Elopement Risk assessment dated [DATE] and GACH 1's PT notes dated 10/31/2025 were reviewed. RNS 1 stated she had completed the Elopement Risk Assessment for Resident 1. RNS 1 stated that prior to completing the assessment, she interviewed Resident 1 and reviewed Resident 1's GACH 1's record. RNS 1 stated she observed Resident 1 was unresponsive, only answering questions selectively. RNS 1 stated she observed Resident 1's arms were moving erratically, and when asked if he could walk, Resident 1 did not provide a clear yes or no response. RNS 1 stated based on her observations, Resident 1 was non-ambulatory (not walking) and unable to self-propel in a wheelchair. RNS 1 stated that in her assessment, he looked like he could not walk. Registered Nurse Supervisor (RNS) 1 stated that Resident 1 was at high risk for elopement. RNS stated Resident 1's elopement risk assessment was inaccurate. During an interview on 11/09/2025 at 12:27 p.m. with the Administrator (ADM), the ADM stated that she was made aware Resident 1's elopement risk assessment had been completed inaccurately. The ADM stated that appropriate interventions should have been implemented to monitor Resident 1 for elopement. The ADM stated that when assessments were inaccurate, residents' safety is placed at risk.During a review of the facility's policy and procedure (P&P) titled, admission Assessment and Follow Up: Role of the Nurse dated 9/2012, the P&P indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments. Cross Reference F689

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure one of three sampled residents (Resident 1), who required minimal assistance with ambulation (walking) using a front wheel walker (FWW- assistive walking device), did not exit through the unsupervised, non-alarmed front door without staff knowledge. The facility failed to: 1. Ensure there was a system in place to monitor the facility's front door after 6:30 pm during times when the receptionist was not present to prevent residents from leaving the facility without staff knowledge. 2. Ensure Resident 1 was accurately assessed for the risk of elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision) and developed a plan of care with intervention to prevent elopement. Resident 1 was assessed as low risk for elopement due to being unable to ambulate (walk) and unable to self-propel a wheelchair. According to Resident 1's general acute care hospital (GACH) 1 record titled Physical Therapy Notes and an interview with the facility's occupational Therapist (OT- profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Resident 1 required minimal assistance (a person can perform most of the walking task independently but requires some help which may include minor physical guidance, verbal cues, or setup) with ambulation using a FWW. 3. Ensure there were interventions in place to ensure Resident 1's safety and address possible elopement. 4. Ensure staff responded to the alarm when the emergency exit door, located on Station 3, was alarming on 11/7/2025 for eight minutes to ensure door was secure and no resident had eloped (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision). As a result of these deficient practices, Resident 1 eloped from the facility on 11/4/2025 at approximately 8:00 p.m. On 11/4/2025 Resident 1 was found at a local restaurant located approximately one mile away from the facility. While at the restaurant Resident 1 complained of shortness of breath, 911 (a phone number used to contact the emergency services) was called and the resident was transported to the GACH. Upon arrival at the GACH on the same day at 11:04 p.m., Resident 1 experienced a cardiac arrest (heart attack) and was pronounced dead on 11/4/2025 at 11:39 pm. These deficient practices placed 13 residents, assessed as being at risk of elopement, at an increased risk of leaving the facility's premises and being exposed to adverse environmental conditions (rain and/or cold), hypothermia (a dangerously low body temperature), injuries from motor vehicle accidents, medical complications, and/or death. On 11/08/2025 at 1:35 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM) due to the facility's failure to assess, monitor and supervise Resident 1 to prevent the resident's elopement from the facility on 11/04/2025. On 11/10/2025 the facility submitted an acceptable IJ Removal Plan ([IJRP]) interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 11/10/2025 at 1:26 p.m., in the presence of the facility's Administrator (ADM).The IJRP included the following immediate actions: 1. On 11/5/25, the Elopement Evaluation for 73 active residents was completed by the Director of Staff Development (DSD), Infection Prevention Nurse (IPN) and Case Manager (CM). There were 13 residents identified to be at risk for elopement. The Elopement Evaluation will be completed upon admission, readmission, quarterly, annually, and as needed by the Minimum Data Set Nurse (MDSN)/ Designee. Upon completion of elopement evaluation by the licensed nurse, the Director of Nursing (DON)/Designee will review for accuracy. Resident centered care plans with emphasis on elopement interventions will be reviewed, updated, and completed to ensure resident safety upon completion of the Elopement Evaluation. After completion of Elopement Evaluation, the Licensed Nurse will initiate interventions/measures such as one to one (1:1 -involves a sitter or companion to prevent harm) monitoring, sitter (a person who provides non-medical supervision to a resident), hourly rounding, place resident in a supervised area when in wheelchair, re-route resident when attempting to seek exit, engage resident in activities of choice. 2. On 11/5/25, the care plan for the 13 residents identified to be at risk for elopement was reviewed and updated by DON/Designee. The care plan interventions of the 13 residents included measures such as: hourly rounding, placed in supervised area, redirection / rerouting. Two residents currently placed on 1:1 monitoring for 24 hours and will be evaluated by the Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received timely and appropriate medication administration upon admission. This deficient practice resulted in failure to accurately transcribe and process Resident 1's physician orders, resulting in a delay in administering eight prescribed medications for serious medical conditions. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted from GACH 1 to the facility on [DATE] with the diagnosis including acute myocardial infraction (MI-heart attack), presence of coronary angioplasty implant and graft (minimally invasive procedure used to open narrowed or blocked coronary [arteries which surround and supply the heart] arteries), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) chronic obstructive pulmonary disease (COPD-lung disease) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 1's Order Summary Report dated 11/07/2025, the Order Summary Report indicated Resident 1 was to receive the following medications on 11/04/2025 1. Aspirin 81miligrams (mg unit of measurement) once a day for cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain). 2. Atorvastatin 80 mg give at bedtime for hyperlipidemia (high cholesterol).3. Carvedilol 3.125 mg twice a day for hypertension (high blood pressure). 4. Clopidogrel 75 mg once a day for deep vein thrombosis (DVT- blood clot).5. Levetiracetam 500 mg every 12 hours (hrs.) for seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).6. Olanzapine 10 mg at bedtime for psychotic behavior.7. Pantoprazole 40 mg in the morning for gastroesophageal reflux disease (GERD-burning sensation in the chest heartburn). 8. Spironolactone 25 mg once a day for heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen).During a phone interview on 11/07/2025 at 11:18 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she had cared for Resident 1 on 11/03/2025 and first saw the resident around 11:30 p.m. in bed. LVN 4 stated she was unable to locate Resident 1's admission packet (hospital orders) and therefore did not input any of the resident's medications into the electronic system.During an interview on 11/07/2025 at 1:59 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated that she began entering Resident 1's medication orders into the electronic system on 11/04/2025. RNS 1 stated that Resident 1 had arrived at the facility on 11/03/2025, but no arrival time was documented. RNS 1 stated that the LVN should have entered the medication orders upon the resident's arrival. RNS 1 stated that this delay resulted in a delay in care for Resident 1.During an interview on 11/09/2025 at 12:27 p.m., with the Administrator (ADM), the ADM stated that medications should be ordered immediately upon a resident's arrival to ensure timely care and to meet the resident's medical needs.During a review of the facility's policy and procedure (P&P) titled Medication ordering and receiving from pharmacy the P&P indicated Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. Medication orders are written on a medication order form (i.e. telephone order sheet, reorder form, etc.) provided by the pharmacy or written in the chart by the physician or authorized personnel and transmitted to the pharmacy. The written entry includes:a. Date orderedb. Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number.c. Resident's name and other identifying information, when necessaryd. Medication name and strength, when indicatede. Directions for use, if a new order, or direction changes to a previous order with indication as to whether a new supply is needed from the pharmacyf. Name of pharmacy supplier if other than provider pharmacy.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to maintain and implement an ongoing Quality Assurance and Performance Improvement (QAPI) program as required. The facility was unable to provide documentation or evidence of any QAPI activities, committee meetings, or performance improvement projects since 7/17/2025.This failure had the potential to negatively impact the quality of resident care by allowing facility-identified issues to go unaddressed or reoccur, thereby compromising resident safety and regulatory compliance.Findings:During a review of the facility's QAPI plan dated 07/17/2025 indicated that this was the last recorded meeting of the facility's Quality Assurance (QA) committee.During an interview conducted on 11/09/2025 at 10:26 a.m., with the Administrator (ADM), the ADM stated that the QA committee was expected to meet monthly to review prior concerns, discuss current issues, and revise care plans as needed. The ADM stated that the last QA meeting occurred on 07/17/2025. The ADM stated that failure to hold regular QA meetings places residents' safety at risk and is not aligned with the facility's QAPI policy. During a review of the facility's policy & procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) plan dated 2/2020, the P&P indicated This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care pursue methods to improve care quality, and resolve identified problems. This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committeesThe objectives of the QAPI Plan are to:1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services.2. Reinforce and build upon effective systems and processes related to the delivery of quality care and services.3. Provide structure and processes to correct identified quality and/or safety deficiencies.4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome.5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability.6. Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility; and7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program.