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	12/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights (a device used by residents to call for assistance from facility staff) for two of three sampled residents (Resident 3 and Resident 4) were within reach of the residents. This deficient practice resulted in Resident 3 and 4 not being able to use their call lights, which forced them to yell for help, causing a delay in care and services for Residents 3 and 4. Findings: a. During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including convulsions (rapid, full-body [or sometimes just part-of-body] shaking and stiffening) and muscle weakness. During a review of Resident 3's History and Physical (H&P), dated 7/11/2025, the H&P indicated, Resident 3 had capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 10/8/2025, the MDS indicated Resident 3 was usually able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was intact. During a concurrent interview and observation on 10/10/2025, at 3:20 p.m., Resident 3, who was in his room, was heard yelling nurse. Upon entering Resident 3's room, he was observed lying in bed on his left side looking for his call light. Resident 3's call light was observed wedged between Resident 3's mattress and his side rail, dangling, and out of Resident 3's reach. Resident 3 stated this always happens and he could not find his call light, so he yelled for help. Resident 3 stated he needed someone to help him now because it was difficult moving himself in bed and reaching for things. Resident 3 stated he did not want to lie on his left side anymore and wanted to be repositioned. Resident 3 stated he was frustrated because he could not find his call light and had to yell to get help. During a concurrent interview and observation on 10/10/2025, at 3:25 p. m., Certified Nursing Assistant (CNA) 2 entered Resident 3's room, told Resident 3 she heard him yelling. Resident 3 was heard asking CNA 2, where was his call light and telling her he was yelling for help because he wanted to be repositioned in bed. CNA 2 was observed looking for Resident 3's call light and found it wedged between the mattress and the side rail of Resident 3's bed, dangling and out of Resident 3's reach. CNA 2 stated the nursing staff should have checked to make sure Resident 3 ‘s call light was in reach before leaving his room. b. During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fibromyalgia (widespread muscle pain and tenderness, sleep problems) back pain and dementia (a progressive state of decline in mental abilities). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 was usually able to understand and be understood by others. The MDS indicated Resident 1's cognition (ability to register and recall information) was moderately impaired. During a review of Resident 4's Care Plan, revised on 8/10/2021, the Care Plan indicated Resident 4 was at risk for recurrent falls due to a history of falls, use of multiple pain medications, noncompliance with nursing care, a tendency to sleep sitting at the edge of the bed, and going to the bathroom without calling for assistance. The Care Plan's interventions included placing Resident 4's call light within reach. During a concurrent interview and observation on 10/10/2025, at 3:10 p.m., Resident 4 was observed sitting on the edge of her bed. Resident 4's call light was observed out of Resident 4's reach, sitting on the bedside table of B bed. Resident 4 stated she had been looking for her call light but could not find it. Resident 4 stated when she needed help, she would yell for a nurse because she had no other way to request assistance. Resident 4 stated she could hear someone across the hall yelling, which happened often and disrupts her rest. Resident 4 stated the yelling probably was because a resident didn't have their call light either and she was frustrated because she didn't have her call light and because her neighbor yelled for a nurse all the time. During a concurrent interview and observation on 10/10/2025, at 3:35 p.m., CNA 2 was observed in Resident 4's room, Resident 4 was overheard asking CNA 2, where was her call light? CNA 2 looked for Resident 4's call light and located it on the bedside table of B' Bed. (Resident 4 was in C bed). CNA 2 stated that Resident 4's call light was not in Resident 4's reach, someone must have moved it. CNA 4 stated Resident 4's should have access to her call light so she could ask for assistance, or she might try to get up on her own, fall and get hurt. During an interview on 10/22/2024 at 4:30 p.m., the Director of Nursing (DON) stated staff should make frequent room rounds to ensure residents' call lights were accessible to the residents. The DON stated Residents 3 and 4 were at greater risk for injuries and falls when they could not reach their call lights because they might try to reach for items or get out of bed on their own. During a review of the facility's

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 the responsible Party (RP) for one of three sampled residents (Resident 1) was notified when Resident 1 had a change of condition (COC) This deficient practice resulted in Resident 1's RP visiting Resident 1 at the facility and observing Resident 1 sleepier than usual, but she was unaware that Resident 1 had been given multiple medications that were not his. This deficient practice had the potential for Resident 1's RP to be unable to make decisions regarding Resident 1's care. Findings: 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 was readmitted on [DATE] with diagnoses that included hemiplegia (total loss of movement and feeling in one side of body) and hemiparesis (one sided weakness) affecting the resident's right side, atrial fibrillation ([a-fib] heart rhythm disorder) and type 2 DM. During a review of Resident 1's History and Physical (H/P), dated 8/10/2025, the H/P indicated Resident 1 does not have the capacity to understand and make decisions but was able to make decisions for activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/14/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think and reason) with the ability to understand and be understood by others During a review of Resident 1's Change of Condition (COC) document, dated 10/22/2025, the report indicated Resident 1 received the wrong medication. During an interview on 10/23/2025, at 8:45 a.m., Resident 1 stated on 10/22/2025 he was transported to a GACH because he received the wrong medication. Resident 1 stated yesterday morning (10/22/2025), he was given medication by a new nurse (SN 1). Resident 1 stated SN 1 did not ask what his name was, his birth date nor did she review his medications with him prior to administering them to him. Resident 1 stated he did not remember much of yesterday, his wife was the one that noticed something was wrong him. During a telephone interview on 10/23/2025, at 10:30 a.m., Resident 1 ‘s Responsible Party (RP 1) stated on 10/22/2025 she noticed that Resident 1 was sleepier than usual. RP 1 stated she asked Certified Nurse Assistant (CNA) 1 to take RP 1‘s blood pressure and his blood pressure results were in the 80's or low 90's. RP 1 stated she was concerned because Resident 1 was so sleepy that he would not drink his water and he could not remember if he slept well the night before, which was unusual for him. RP 1 said the DON entered the room around 1 p.m. to assess Resident 1 and that was when she was first notified that Resident 1 had received the wrong medication that morning. During a telephone interview on 10/24/2025, at 2:37 p.m., LVN 1 stated The DON instructed her to complete a COC form and notify Resident 1's RP of the medication error. LVN 1 stated she failed to notify Resident 1's RP of Resident 1's COC because she was focused on monitoring Resident 1 for any changes and forgot to call his RP. During an interview on 10/24/2025, at 4:17 p.m., the DON stated when LVN 1 reported the medication error on 10/22/2025 at approximately 10 a.m., he instructed her to notify Resident 1's RP. The DON stated LVN 1 left work early that day, at approximately 1 p. m., but did not inform him that she had not notified Resident 1's R that he had received wrong medications. During a review of the facility's Policy and Procedure (P/P) titled, Change of Condition, revised 8/25/2021, the P/P indicated the following, the purpose of the policy is to ensure residents, family, legal representatives, physicians are informed of changes to the resident's condition, the facility must inform the resident. and notify, consistent with his authority, the resident's representative where there is. a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications, or the need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences). During a review of the facility's P/P titled, Medication Errors revised 6/28/2022, the P/P indicated upon discovery of an error, notification will be immediately given to the. resident and responsible party.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Licensed Vocational Nurse (LVN) 1 provided direct supervision to Student Nurse (SN) 1 on 10/22/2025 when administering scheduled 9 am medications to one of three sampled residents Resident 1) along with not ensuring the five rights of medication administration were abided by. This deficient practice resulted in Resident 1 receiving Valsartan (a medication that lowers the blood pressure), multivitamin and minerals, Guaifenesin (a medication that helps loosen and thin mucus in the throat and chest) extended release ([ER] version of pill where medicine steadily throughout the day in the body), Eliquis (a medication used to prevent blood lots, thin blood), Carvedilol (used to lower the blood pressure and heart rate), Keppra (a medication used to treat seizures), Magnesium Oxide (a mineral supplement which could cause diarrhea, bloating and stomach cramps) in error. This deficient practice resulted in Resident 1 not receiving his prescribed medications; Glipizide (a medication used to treat type 2 diabetes [DM] a disorder characterized by difficulty in b/s control and poor wound healing), Metformin (a medication used to treat high b/s), Baclofen (a medication used to treat tightness and stiffness caused by muscle spasms), vitamin D, Iron, Finasteride (a medication used to treat an enlarged prostate [male organ]) and Lacosamide (a medication used to treat seizures). Resident 1 was subsequently transported to a General Acute Care Hospital (GACH) for monitoring and evaluation resulting in invasive venipunctures ([blood draw] removing blood from a vein using a needle), unplanned exposure to radiation via an Xray (a medical imaging that uses radiation to create pictures of the inside of the body) and a Computed Tomography ([CT] high power studies that takes multiple x-rays from different angles to create pictures of inside the body) scan. This deficient practice placed Resident 1 at risk for harm, such as allergic reactions, alteration in blood sugar [b/s], bleeding and death.Findings: 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 was readmitted on [DATE] with diagnoses that included hemiplegia (total loss of movement and feeling in one side of body) and hemiparesis (one sided weakness) affecting the resident's right side, atrial fibrillation ([a-fib] heart rhythm disorder) and type 2 DM. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/14/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think and reason) with the ability to understand and be understood by others. During a review of Resident 1's Change of Condition (COC) document, dated 10/22/2025, the COC indicated Resident 1 received the wrong medication. During a review of Resident 1's Order Summary Report (Physician's Order), dated 10/22/2025, the Physician' Order indicated to transfer Resident 1 to a GACH emergency room (ER) or further evaluation related to the wrong medication administration. During a review of Resident 1's Nurses Progress Notes, dated 10/22/2025, the Nurse Progress Note indicated Resident 1 was transferred to a GACH via 911 for evaluation. During a review of the GACH ER records dated 10/22/2025, the ER records indicated Resident 1 was admitted to the GACH on 10/22/2025 and presented to the ER for evaluation due to receiving the wrong medications at the skilled nursing facility (SNF) Resident 1 resided at. The ER records indicated Resident 1 underwent blood tests and radiological studies to rule out the risk of bleeding and other adverse drug effects. During an interview on 10/23/2025, at 8:45 a.m., Resident 1 stated on 10/22/2025 he was transported to a GACH because he received the wrong medication. Resident 1 stated yesterday morning (10/22/2025), he was given medication by a new nurse (SN 1). Resident 1 stated SN 1 did not ask what his name was, his birth date nor did she review his medications with him prior to administering them to him. Resident 1 stated he did not remember much of yesterday, his wife was the one that noticed something was wrong him. During an interview on 10/23/2025, at 1:30 p.m., the DON stated on 10/22/2025 at approximately 10 a.m., LVN 1 informed him that she was mentoring SN 1 and SN 1 had given Resident 1 the wrong medication. The DON stated LVN 1 reported that Resident 1 received Resident 2's scheduled 9 a.m., medications in error. The DON stated he assessed Resident 1 at approximately 1:30 p.m. and found Resident 1 was sleepy but arousable with his BP was in the 90s. The DON stated he informed the RP that Resident 1 had received several medications in error and the RP insisted that he call 911 to transport Resident 1 to the GACH. The DON stated when EMS arrived to the facility he provided them with a list of medications that Resident 1 received in error. During a telephone interview on 10/23/2025, at 2:18 p.m., SN 1 stated he was allowed to administer medications under the direct supervision of a licensed nurse and on 10/22/2025 he was assigned to shadow LVN 1 during a medication

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Licensed Vocational Nurse (LVN) 1 provided direct supervision to Student Nurse (SN) 1 on 10/22/2025 when administering 9 a.m., scheduled medications to one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 receiving Valsartan (a medication that lowers the blood pressure), multivitamin and minerals, Guaifenesin (a medication that helps loosen and thin mucus in the throat and chest) extended release ([ER] version of pill where medicine steadily throughout the day in the body), Eliquis (a medication used to prevent blood lots, thin blood), Carvedilol (used to lower the blood pressure and heart rate), Keppra (a medication used to treat seizures), Magnesium Oxide (a mineral supplement which could cause diarrhea, bloating and stomach cramps) in error. This deficient practice resulted in Resident 1 not receiving his prescribed medications; Glipizide (a medication used to treat type 2 diabetes [DM] a disorder characterized by difficulty in b/s control and poor wound healing), Metformin (a medication used to treat high b/s), Baclofen (a medication used to treat tightness and stiffness caused by muscle spasms), vitamin D, Iron, Finasteride (a medication used to treat an enlarged prostate [male organ]) and Lacosamide (a medication used to treat seizures). Resident 1 was subsequently transported to a General Acute Care Hospital (GACH) for monitoring and evaluation resulting in invasive venipunctures ([blood draw] removing blood from a vein using a needle), unplanned exposure to radiation via an Xray (a medical imaging that uses radiation to create pictures of the inside of the body) and a Computed Tomography ([CT] high power studies that takes multiple x-rays from different angles to create pictures of inside the body) scan. This deficient practice placed Resident 1 at risk for harm, such as allergic reactions, alteration in blood sugar [b/s], bleeding and death.Findings: 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 was readmitted on [DATE] with diagnoses that included hemiplegia (total loss of movement and feeling in one side of body) and hemiparesis (one sided weakness) affecting the resident's right side, atrial fibrillation ([a-fib] heart rhythm disorder) and type 2 DM. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/14/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think and reason) with the ability to understand and be understood by others. During a review of Resident 1's Change of Condition (COC) document, dated 10/22/2025, the COC indicated Resident 1 received the wrong medication. During a review of Resident 1's Order Summary Report (Physician's Order), dated 10/22/2025, the Physician' Order indicated to transfer Resident 1 to a GACH emergency room (ER) or further evaluation related to the wrong medication administration. During a review of Resident 1's Nurses Progress Notes, dated 10/22/2025, the Nurse Progress Note indicated Resident 1 was transferred to a GACH via 911 for evaluation. During a review of the GACH ER records dated 10/22/2025, the ER records indicated Resident 1 was admitted to the GACH on 10/22/2025 and presented to the ER for evaluation due to receiving the wrong medications at the skilled nursing facility (SNF) Resident 1 resided at. The ER records indicated Resident 1 underwent blood tests and radiological studies to rule out the risk of bleeding and other adverse drug effects. During a review of the facility's Cell Phone Log, dated 10/22/2025, the Cell Phone Log indicated the following text messages between LVN 1 and Resident 1's physician: 1. 9:52 a.m. - a text message was sent to Resident 1's physician indicating Resident 1 received the wrong medications 2. 9:56 a.m. - a text message from Resident 1's physician indicating type it out please, what was the medication error? 3. 9:58 a.m. - a text message from Resident 1's physician indicating, Resident 1 received medications that were for another resident (Resident 2). I am trying to send a list of medications, but the internet went down, I am unable to send his list of medications to compare to the ones he received. 4. 10:27 a.m. - a text message Resident 1's physician indicating to monitor blood pressure for 72 hours, bleeding precautions for 10 days, let the Director of Nursing (DON) and Administrator (ADM) know of the medication error which can be fatal, needs to be logged via appropriate channels, do not let it happen again, I cannot see pictures, type out medication names and dosing please. 5. 11:27 a.m. - a text message was sent to Resident 1's physician indicating Resident 1 received the following medications: Valsartan 40 mg, Multivitamin and minerals, Guaifenesin ER 600 mg, Eliquis 5 mg, Carvedilol 6.25 mg, Keppra 250 mg, Mag Ox 400 mg. 6. 11:30 a.m. - a text message sent to Resident 1's physician indicating Resident 1's prescribed medications were held; Glipizide 5 mg, Metformin 100 mg, Baclofen 10 mg, Vitamin D, Iron, Finasteride 5 mg and Lacosamide 50 mg. 7. 2:01 p.m. - a text message sent to Resident 1's Physician