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	02/23/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized care plan with measurable objectives, timeframes, and interventions to meet the resident's needs for one of three sampled residents (Resident 1).The facility did not develop an individualized care plan addressing Resident 1's refusal of care and treatment, including goals and interventions. This deficient practice had the potential to negatively affect the delivery of necessary care and services. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and atrial fibrillation (irregular heartbeat).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/5/2026, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was severely impaired and required maximal assistance (helper does more than half the effort) with toileting, bathing, and showering. During a review of Resident 1's Nurses Progress Notes dated 11/15/2025, the Nurses Progress Notes indicated Resident 1 refusing to be showered. During a review of Resident 1's Interdisciplinary (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Care Conference Note dated 11/24/2025, the IDT Care Conference Note indicated Resident 1 refusing meals and medications. During a review of Resident 1's Follow-Up Note dated 12/26/2025, the Follow-Up Note indicated Resident 1 refused vital signs.During a concurrent interview and record review on 2/20/2026 at 2:44 p.m. with Licensed Vocational Nurse (LVN) 1, reviewed Resident 1's care plans. LVN 1 stated that there was no care plan developed for Resident 1's refusal of care. LVN 1 stated a care plan should have been developed so staff would be aware of the resident's needs and know how to appropriately respond. LVN 1 stated having a care plan addressing refusal of care was important because the lack of one could place Resident 1 at risk for skin breakdown and the care plan serves as a communication tool for staff. During an interview on 2/20/2026 at 3:59 p.m., with the Director of Nursing (DON), the DON stated when a resident refuses care, a care plan should be developed to help guide the staff on how to direct care for the residents. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated, 8/25/2021, the P&P indicated, Each resident's comprehensive care plan is designed to incorporate identified problem areas and incorporate risk and contributing factors associated with identified problems. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plan for one of three sampled residents (Resident 1) was revised to address fall prevention needs. The facility failed to:1. Revised Resident 1's care plan to reflect the resident's current physical and cognitive (ability to think, understand, learn, and remember) status.This deficient practice had the potential to place Resident 1 at risk for preventable falls and inadequate supervision. Resident 1 subsequently experienced an unwitnessed fall on 2/20/2026, which resulted in multiple fractures (broken bone) to the left ribs.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE], with diagnosis including multiple rib fractures on the left side, dementia (loss of memory, language, problem-solving and other thinking abilities) and anxiety (emotion characterized by feelings of tension, worried thoughts).During a review of Resident 1's History and Physical (H&P), dated 9/28/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 2/8/2026, the MDS indicated, Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living (ADL's) like toileting and bathing.During a review of Resident 1's Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death), dated 1/11/2026, the COC indicated Resident 1 was found sitting on the floor next to her wheel chair (w/c).During a review of Resident 1's care plan titled Risk for Falls secondary to confusion/decreased safety awareness and history of falls (h/o), dated 1/13/2026, the care plan indicated, to determine Resident 1's ability to transfer by herself, educate resident/representative on proper ambulation and transfer techniques, ensure call light is available to resident, evaluate environment to identify factors known to increase risk of falls, if a fall occurs alert provider and if fall occurs, initiate frequent neuro checks and bleeding evaluation per facility protocol.During a review of Resident 1's Interdisciplinary Care Conference Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care), dated 1/16/2026, the IDT indicated Resident 1 had a fall on 1/11/2026, the IDT indicated Resident 1 continued to be at risk for falls due to her cognition changes and dementia. The IDT indicated Resident 1's bed should be in lowest position, provide Resident 1 with a toileting schedule, provide a cup with holder to encourage Resident 1 to drink fluids as she propels herself in her w/c to help prevent fatigue due to Resident 1's decreased safety awareness and educate the staff to ensure adherence to Resident 1's care plan. The IDT indicated to continue to monitor and adjust interventions as needed to promote residents safety and reduce fall risk.During a review of Resident 1's COC dated 2/20/2026 at 9:38 am, the COC indicated Resident 1 was found lying on her back in front of her bed on the floor.During a review of Resident 1's General Acute Care Hospital (GACH) record, dated 2/20/2026, the GACH record indicated Resident 1 was admitted to the GACH after an unwitnessed fall on 2/20/2026 that resulted in multiple fractures to the left ribs.During a concurrent interview and record review on 2/23/2026 at 11:23 a.m. with the Infection Preventionist (IP), Resident 1's care plan titled Risk for Falls, dated 1/13/2026, and the Change of Condition (COC) report dated 1/11/2026, were reviewed. The IP stated the care plan should have been revised to reflect Resident 1 had an actual fall on 1/11/2026 and that a new plan of care should have been implemented. The IP stated that Resident 1's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety was at risk when the care plan was not updated following the fall on 1/11/2026.During an interview on 2/23/2026 at 2:45 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had an actual fall on 1/11/2026 and that the Risk for Falls care plan had not been revised to reflect this incident. The DON stated that no new interventions were added to Resident 1's care plan following the fall on 1/11/2026. The DON stated that revising a care plan after a fall was important because it identifies updated interventions and serves as an indicator of the care the resident should be receiving.During a review of the facility's policy and procedure (P&P) titled, Care plan Comprehensive, dated 8/25/2021, the P&P indicated, A individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident.