

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  03/06/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record reviews, the facility failed to ensure one of three sampled residents (Resident 1) with severe cognitive (ability to think, understand, learn, and remember) impairment and high fall risk was provided with fall prevention measures, including the use of bed rails (a barrier attached to the side of a bed) as ordered by Resident 1's physician on 2/23/2026. The facility failed to: 1. Implement fall prevention interventions including use of bedrails immediately following Resident 1's falls on 2/20/2026 and 2/27/2026. 2. Follow a physician's order written on 2/23/2026 to install bed rails and inform Resident 1's physician of the delay in installing the ordered bed rails. 3. Revised Resident 1's care plan to include post fall interventions to prevent future falls. 4. Follow facility's policy and procedure (P&amp;P) titled, Falls-Clinical Protocol, dated 2018, which indicated the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address the risks of falling. These failures resulted in Resident 1 falling on 2/27/2026 and 3/1/2026. On 3/1/2026 Resident 1 was transferred to a General Acute Care Hospital (GACH). Resident 1 sustained a possible nondisplaced lateral malleolus (bony prominences on either side of the ankle) fracture [broken bone] of uncertain chronicity [medical condition where it is unclear if symptoms will be long-lasting (chronic) or temporary (acute)]. 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), multiple fractures (broken bones) of the ribs and history of falls. During a review of Resident 1's History &amp; Physical (H&amp;P) dated 9/28/2026, the H&amp;P indicated that Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Care Plan titled Resident 1 has a history of confusion/decreased safety awareness secondary to dementia, dated 1/13/2026, the Care plan goal indicated Resident 1 will be free of falls and Resident 1 will return to previous level of activity. The Care Plan interventions included to cue resident for safety, and educate resident and resident representative regarding proper ambulation and transfer techniques. During a review of Resident 1's Nursing Documentation Evaluation, dated 2/12/2026, the Nursing Documentation Evaluation indicated, Resident 1's fall risk factor including history of falls in the last six months, disoriented/confused, poor safety judgement, and impaired balance. During a review of Resident 1's Minimum Data Set (MDS ? a resident assessment tool) dated 2/20/2025, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting, bathing, and showering. During a review of Resident 1's Change of Condition (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 2/20/2026, the COC indicated, Resident 1 was found laying on her back at the end of the bed. The COC indicated Resident 1 reports hitting her left ribs and her back. Resident 1 denies hitting her head. Resident 1 reports pain on her upper back with a pain scale (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, (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
---	-------	-----------

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  03/06/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and 10- the worse pain possible) of 4/10, pain medication was administered. During a review of Resident 1's Order Summary Report dated 2/23/2026, the Order Summary Report indicated an order for side rails with fall precautions. During a review of Resident 1's Physical Therapy (PT- licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation dated 2/25/2026, the PT Evaluation indicated Resident 1 needs moderate assistance to ambulate (walk) 10 feet (ft- unit of measurement) with two wheeled walker ( assistive device used to walk). During a review of Resident 1's COC dated 2/27/2026, the COC indicated Resident 1 was found sitting on the floor near her doorway. The COC indicated Resident 1 reported she attempted to get up without assistance. During a review of Resident 1's IDT Care Conference Note dated 2/27/2026, the IDT Care Conference Note indicated Resident 1 had a recent fall resulting in a rib fracture on 2/20/2026, as well as another fall on 2/27/2026. Resident 1 has decreased safety awareness and attempts to ambulate independently. On 2/27/2026, a Certified Nursing Assistant (CNA) placed Resident 1 on a shower chair and briefly left to gather supplies. Upon returning, the CNA found Resident 1 on the floor. The notes indicated interventions including providing cueing for safety and placing bilateral mats at the bedside. During a review of Resident 1's x-ray (imaging test that produce pictures of structures inside the body, particularly bones) of left tibia and fibula (two bones of the lower leg), dated 3/1/2026, the x-ray of left tibia and fibula indicated, possible lateral malleolus nondisplaced fracture, chronicity uncertain. During an observation on 3/6/2026 at 8:30 a.m. in Resident 1's room, bed rails were present on both sides at the head of the bed. No floor mats (cushioned pads designed to help prevent injury in the event of a fall) were observed next to the bed. Resident 1 was not in the room and was reported to have been admitted to a GACH. During an interview on 3/6/2026 at 9:00 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1's care needs. CNA 1 stated Resident 1 was dependent on ADL's and required staff assistance during ambulation and used a wheelchair. CNA 1 stated Resident 1 was considered a fall risk and did not have bed rails installed until after the resident was admitted to the hospital on [DATE]. CNA 1 stated residents identified as fall risks should have interventions in place, which may include a low bed, floor mats, side rails, bed alarms (a pad with sensors that alerts staff if a resident attempts to stand unassisted), and signage at the foot of the bed indicating fall risk status. CNA 1 stated Resident 1 had a history of attempting to get out of bed without assistance and required frequent monitoring. CNA 1 stated staff were expected to conduct rounds every two hours and as needed. During a concurrent interview and record review on 3/6/2026 at 9:15 a.m. with License Vocational Nurse (LVN) 1, Resident 1's Communication Notes dated 3/1/2026 were reviewed. The Communication Notes indicated that Resident 1's Family Member (FM)1 expressed ongoing concerns and repeatedly requested that bed rails be installed on Resident 1's bed. The request had been made to both the Director of Nursing (DON) and the charge nurse. The Communication Notes indicated staff requested that the appropriate paperwork be provided so the bed rails could be installed. LVN 1 stated Resident 1's FM 1 had repeatedly requested bed rails since the resident's initial fall on 2/20/2026. LVN 1 stated she did not know why bed rails were not installed after the first fall on 2/20/2026. LVN 1 stated bed rails could have potentially prevented Resident 1 from rolling out of bed during the fall on 3/1/2026. LVN 1 stated on 3/1/2026 at approximately 6:00 p.m., as she approached Resident 1's room, she saw Resident 1 was falling from the bed to the floor. LVN 1 stated she immediately entered the room and called for assistance. LVN 1 stated Resident 1 was assessed after the fall and did not sustain injuries, and that no new interventions were implemented following the incident. LVN 1 stated Resident 1 did not have floor mats, bed rails, or a bed alarm at the time of the fall on 3/1/2026. LVN 1 stated for residents identified as a fall risk, staff should implement fall prevention interventions based on the residents' assessment and care plan. LVN 1 stated these interventions may include placing the bed in the low position, activating a bed alarm, using bed rails when appropriate, placing floor mats, encouraging the resident to use the call light, and providing assistance with ambulation as needed. LVN 1 stated that she was unable to explain why the bed rails were not installed in a timely (continued on next page)</p>		

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  03/06/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>manner or why the physician was not notified of the delay. LVN 1 stated Resident 1 did not have bed rails installed after her first fall on 2/20/2026 and ordered on 2/23/2026. LVN 1 stated if appropriate fall prevention interventions were not in place, residents who are at risk for falls and attempt to get out of bed or ambulate without assistance may sustain falls resulting in fractures, bleeding in residents on blood thinners or death. During a concurrent interview and record review on 3/6/2026 at 10:30 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 1's Order Summary dated 2/23/2026 was reviewed. The Order Summary indicated a physician's order for bed rails with fall precautions. RNS 1 stated the facility's process when a resident requires bed rails was to complete a bed rail assessment, obtain a physician's order, and obtain consent from the resident and/or the resident's representative prior to implementation. RNS 1 stated that once these steps were completed, the bed rails should be installed without delay. RNS 1 stated staff should notify the physician if there was any delay in implementing a physician's order to ensure residents receive timely and appropriate care. RNS 1 stated physician orders reflect the clinician's judgment regarding interventions necessary to maintain the resident's safety and prevent harm. RNS 1 stated delays in implementing ordered interventions may place the resident at risk because the intended safety measure was not in place. RNS 1 stated she was unable to explain why the side rails were not installed on Resident 1's bed until 3/2/2026. RNS 1 stated according to Resident 1's medical record and the facility's documentation, no interventions were implemented immediately following the falls on 2/27/2026 and 3/1/2026. RNS 1 stated bed rails could have prevented the resident from falling from the bed. RNS 1 stated Resident 1 was admitted to GACH on 3/1/2026 at 5:51 p.m. after being found unresponsive in her wheelchair near the nurses' station by the Licensed Vocational Nurse (LVN). RNS 1 stated she had observed the resident in her wheelchair in the hallway shortly before the event and the resident did not appear to be in any distress. During a concurrent interview and record review on 3/6/2026 at 11:15 a.m. with the Director of Nursing (DON), Resident 1's Care Plans were reviewed. The Care Plan indicated that no new interventions were implemented following Resident 1's falls on 2/27/2026 and 3/1/2026. The DON stated no new physician orders or additional fall prevention interventions were implemented after these two falls. The DON stated Resident 1's FM 1 had been requesting bed rails since the initial fall on 2/20/2026. The DON stated Resident 1 was identified as a fall risk due to her history of previous falls and her diagnosis of dementia. The DON stated additional interventions, such as a bed alarm and bed rails, should have been implemented and may have prevented repeat falls. The DON stated bed rails were intended to provide support for mobility, assist with repositioning, and help prevent falls. The DON stated facility policy requires a bed rail assessment prior to installation, followed by obtaining a physician's order and securing consent from the resident and/or resident representative. The DON stated bed rails should be installed without delay, within 24 hours. The DON stated the maintenance department was not contacted to install the bed rails until 3/2/2026, and she did not know why the installation was not completed sooner. The DON stated timely implementation of physician orders and care plan interventions was essential to resident safety. The DON stated failure to promptly implement interventions may increase the resident's risk for repeat falls and related injuries, including head trauma, fractures, or death. The DON stated Resident 1's FM 1 had been requesting bed rails since the resident's initial fall on 2/20/2026. During an interview on 3/6/2026 at 11:45 a.m. with Maintenance Director (MD), MD stated he was first made aware that the bed rails needed to be installed during the facility's stand-up meeting on 3/2/2026, by the DON. MD acknowledged that no prior notification or request had been made regarding the installation of the bed rails before that date. MD stated the bed rails were installed on 3/2/2026. During a review of the facility's policy &amp; procedures (P&amp;P) titled, Falls-Clinical Protocol, dated 2018, the P&amp;P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. During a review of the facility's policy &amp; procedures (P&amp;P) titled, Bed Rails, dated 2018, the P&amp;P indicated, Based on the preceding assessment the staff and physician will identify interventions (continued on next page)</p>		

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  03/06/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.</p>

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  03/06/2026
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record review the facility failed to ensure one of three sampled residents (Resident 1) was assess for the risks of entrapment (event in which a resident is caught, trapped, or entangled in the space in or about the bed rail) and the possible risks and benefits of bed rails ( a barrier attached to the side of a bed) were reviewed prior to installation. The facility failed to:1.Obtain a bed rail assessment (a mandatory, documented evaluation conducted by healthcare staff before using bed rails) before bed rails may be used to ensure they are safe, necessary, and functioning as a physical restraint (devices, or materials used to restrict a person's movement, freedom, or access to their body). 2.Obtain informed consent (voluntary agreement to accept treatment and/ or procedures after receiving education regarding risks, benefits, and alternatives offered) for bed rails from the resident and/or Resident's Representative (is a person authorized to act on behalf of a resident in a long-term care facility). 3.Follow Resident 1's physician's order dated 2/23/2026 to install bed rails with fall precautions in a timely manner.These failures placed Resident 1 at risk for repeated falls on 2/27/2026, 3/1/2026 and potential entrapment.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),multiple fractures (broken bones) of the ribs and history of fallsDuring a review of Resident 1's History &amp; Physical (H&amp;P) dated 9/28/2025 , the H&amp;P indicated that Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Care Plan titled Resident 1 has a history of confusion/decreased safety awareness secondary to dementia, dated 1/13/2026, the Care plan goal indicated Resident 1 will be free of falls and Resident 1 will return to previous level of activity. The Care Plan interventions included to cue resident for safety, and educate resident and resident representative regarding proper ambulation and transfer techniques.During a review of Resident 1's Nursing Documentation Evaluation, dated 2/12/2026, the Nursing Documentation Evaluation indicated, Resident 1's fall risk factor including history of falls in the last six months, disoriented/confused, poor safety judgement, and impaired balance.During a review of Resident 1's Minimum Data Set (MDS ?a resident assessment tool) dated 2/20/2025, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting, bathing, and showering.During a review of Resident 1's Change of Condition (COC a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) dated 2/20/2026, the COC indicated, Resident 1 was found laying on her back at the end of the bed. The COC indicated Resident 1 reports hitting her left ribs and her back. Resident 1 denies hitting her head. Resident 1 reports pain on her upper back with a pain scale (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6-moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible) of 4/10, pain medication administered.During a review of Resident 1's Order Summary Report dated 2/23/2026, the Order Summary Report indicated an order for side rails with fall precautions.During a review of Resident 1's COC dated 2/27/2026, it was noted that Resident 1 was found sitting on the floor near her doorway. The COC indicated that Resident 1 reported she attempted to get up without assistance.During a review of Resident 1's IDT Care Conference Note dated 2/27/2026, the IDT Care Conference Note indicated Resident 1 had a recent fall resulting in a rib fracture on 2/20/2026, as well as another fall on 2/27/2026. Resident 1 has decreased safety awareness and attempts to ambulate independently. On 2/27/2026, a Certified Nursing Assistant (CNA) placed Resident 1 on a shower chair and briefly (continued on next page)</p>		

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  03/06/2026
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>left to gather supplies. Upon returning, the CNA found Resident 1 on the floor. The notes indicated interventions including providing cueing for safety and placing bilateral mats at the bedside. During a review of Resident 1's x-ray (imaging test that produce pictures of structures inside the body, particularly bones) of left tibia and fibula (two bones of the lower leg), dated 3/1/2026, the x-ray of left tibia and fibula indicated, possible lateral malleolus nondisplaced fracture, chronicity uncertain. During an observation on 3/6/2026 at 8:30 a.m. in Resident 1's room, bed rails were present on both sides at the head of the bed. No floor mats (cushioned pads designed to help prevent injury in the event of a fall) were observed next to the bed. Resident 1 was not in the room and was reported to have been admitted to General Acute Care Hospital (GACH). During an interview on 3/6/2026 at 9:00 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated that she is familiar with Resident 1's care. CNA 1 stated Resident 1 was considered a fall risk and did not have bed rails installed until after the resident was admitted to the hospital on [DATE]. During a concurrent interview and record review on 3/6/2026 at 9:15 a.m. with License Vocational Nurse (LVN) 1, Resident 1's Communication Notes dated 3/1/2026 were reviewed. The Communication Notes indicated that Resident 1's Family Member (FM)1 expressed ongoing concerns and repeatedly requested that bed rails be installed on Resident 1's bed. The request had been made to both the Director of Nursing (DON) and the charge nurse. The Communication Notes indicated staff requested that the appropriate paperwork be provided so the bed rails could be installed. LVN 1 stated Resident 1 FM 1 had repeatedly requested bed rails since the resident's initial fall on 2/20/2026. LVN 1 stated she did not know why bed rails were not installed after the first fall on 2/20/2026. LVN 1 stated bed rails could have potentially prevented Resident 1 from rolling out of bed during the fall on 3/1/2026. LVN 1 stated that the facility's process for residents who may require bed rails includes completing a bed rail assessment to ensure the rails are safe, necessary, and not being used as a physical restraint. LVN 1 stated the assessment was used to evaluate safety risks, determine the resident's physical abilities, and identify potential entrapment hazards. LVN 1 stated once the bed rail assessment was completed, the licensed nurse must obtain a physician's order and secure informed consent from the resident and/or the resident's representative, after providing education on the risks, benefits, and alternatives. LVN 1 stated the bed rails should be installed immediately after consent was obtained and the order was written. LVN 1 stated that if there was any delay in installing the bed rails, the physician must be notified promptly. She was unable to explain why the bed rails were not installed in a timely manner or why the physician was not informed of the delay. LVN 1 stated Resident 1 did not have bed rails installed after her fall on 2/20/2026 or after the physician's order was written on 2/23/2026. During a concurrent interview and record review on 3/6/2026 at 10:30 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 1's Order Summary dated 2/23/2026 was reviewed. The Order Summary indicated a physician's order for bed rails with fall precautions. RNS 1 stated the facility's process when a resident requires bed rails was to complete a bed rail assessment, obtain a physician's order, and obtain consent from the resident and/or the resident's representative prior to implementation. RNS 1 stated that once these steps were completed, the bed rails should be installed without delay. RNS 1 stated staff should notify the physician if there was any delay in implementing a physician's order to ensure residents receive timely and appropriate care. RNS 1 stated physician orders reflect the clinician's judgment regarding interventions necessary to maintain the resident's safety and prevent harm. RNS 1 stated delays in implementing ordered interventions may place the resident at risk because the intended safety measure was not in place. RNS 1 stated she was unable to explain why the side rails were not installed on Resident 1's bed until 3/2/2026. During an interview on 3/6/2026 at 11:15 a.m. with the Director of Nursing (DON), The DON stated Resident 1's FM 1 had been requesting bed rails since the initial fall on 2/20/2026. The DON stated Resident 1 was identified as a fall risk due to her history of previous falls and her diagnosis of dementia. The DON stated additional interventions, such as a bed alarm and bed rails, should have been implemented and may have prevented repeat falls. The DON stated bed rails were intended to provide support for mobility, assist with repositioning, and help (continued on next page)</p>		

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  03/06/2026
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>prevent falls. The DON stated facility policy requires a bed rail assessment prior to installation, followed by obtaining a physician's order and securing consent from the resident and/or resident representative. The DON stated bed rails should be installed without delay, within 24 hours. The DON stated the maintenance department was not contacted to install the bed rails until 3/2/2026, and she did not know why the installation was not completed sooner. During an interview on 3/6/2026 at 11:45 a.m. with Maintenance Director (MD), MD stated he was first made aware that the bed rails needed to be installed during the facility's stand-up meeting on 3/2/2026, by the DON. MD stated no prior notification or request had been made regarding the installation of the bed rails before 3/2/2026. MD stated the bed rails were installed on 3/2/2026. During a review of the facility's policy &amp; procedures (P&amp;P) titled, Falls-Clinical Protocol, dated 2018, the P&amp;P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. During a review of the facility's P&amp;P titled, Use of Restraints, [undated], the P&amp;P indicated, Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve symptoms. During a review of the facility's P&amp;P titled, Bed Rails, dated 2018, the P&amp;P indicated, Based on the preceding assessment the staff and physician will identify interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.</p>