

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 03/18/2026
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and Responsible Party (RP) for one of three sampled residents (Resident 2) when Resident 2 received medications that should have been held. This deficient practice resulted in Resident 2's physician and RP being unaware that Resident 2 received medications that should have been held. This deficient practice resulted in the inability of Resident 2's physician to give timely instructions for Resident 2's care and the inability for Resident 2's RP to participate and make decisions in Resident 2's immediate care needs. This deficient practice had the potential for the RP to remain uninformed about changes in Resident 2's health status. 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]. Resident 2 was admitted with diagnoses including type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a slight paralysis or weakness on one side of the body). During a review of Resident 2's History and Physical (H&P) dated 10/10/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 2's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 2 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, maximal assistance (helper does more than half the effort) from staff for dressing and shower/bathing and was dependent (helper does all the effort) on staff for toileting.During a review of Resident 2's Order Summary Report (Physician's Orders) dated 3/18/2026, the report indicated an order was placed for Resident 2 to receive glipizide oral tablet 2.5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) once a day for DM and hold if capillary blood glucose ([CBG] blood sugar) is less than 120, ordered on 3/4/2026.During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2026 to 3/31/2026, the MAR indicated Resident 2's had the following CBG levels:1. On 3/8/2026, Resident 2 had a CBG level of 98.2. On 3/10/2026, Resident 2 had a CBG level of 102.3. On 3/11/2026, Resident 2 had a CBG level of 100.4. On 3/13/2026, Resident 2 had a CBG level of 119.5. On 3/14/2026, Resident 2 had a CBG level of 117.6. On 3/15/2026, Resident 2 had a CBG level of 96.7. On 3/16/2026, Resident 2 had a CBG level of 101.8. On 3/17/2026, Resident 2 had a CBG level of 100.During a continued review of Resident 2's MAR dated 3/1/2026 to 3/31/2026, the MAR indicated Resident 2 received glipizide oral tablet 2.5 mg at 9 a.m. on 3/8/2026, 3/10/2026, 3/11/2026, 3/13/2026, 3/14/2026, 3/15/2026, 3/16/2026, and on 3/17/2026 despite having CBG levels less than 120. During a concurrent interview and record review on 3/18/2026 at 11:19 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 2's MAR dated 3/2026 was reviewed. LVN 3 stated he had administered glipizide when CBG was less than 120, contrary to physician orders. LVN 3 stated he did not notice that there were parameters for administering (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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>glipizide. LVN 3 stated he did not notify the physician of the medication administration errors. LVN 3 stated if he had identified the errors, he would have completed a change of condition (COC), notified the physician, Registered Nurse (RN) supervisor, Director of Nursing (DON), and the resident's family, and rechecked the Resident 2's blood glucose level. During a concurrent interview and record review on 3/18/2026 at 1:04 p.m., with Registered Nurse (RN) 1, Resident 2's Order Summary Report, MAR, Nursing Progress Notes, and COC reports dated 3/2026 was reviewed. RN 1 confirmed glipizide was administered on multiple occasions when the CBG was less than 120. RN 1 stated licensed nurses must check parameters before administering medications and follow physician orders. RN 1 further confirmed there was no documentation in the nursing progress notes or COC which reported the glipizide errors, notification to the physician or the resident's family. During a review of the facility's policy and procedure (P&P) titled, Change in Condition: Notification of, dated 8/25/2021, the P&P indicated the facility must immediately inform the resident, consult with the resident's physician, and notify the resident representative in the event of an accident involving the resident, a significant change in the resident's condition, or a need to alter treatment significantly. During a review of the facility's policy and procedure (P&P) titled, Medication Errors, dated 6/28/2022, the P&P indicated all errors related to the administration of medications must be reported immediately to the Director of Nursing, the attending physician, and the Administrator. Upon discovery of an error, the Director of Nursing would notify the attending physician, resident, and responsible party, and a medication error report would be completed for all medication errors.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (Resident 2) who had a diagnosis of type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and received glipizide (a medication used to lower blood sugar levels) daily for his DM, was administered according to physician's orders for one of three sampled residents (Resident 2). These failures resulted in the resident receiving glipizide on eight separate occasions when Resident 2's capillary blood glucose ([CBG] blood sugar level) was less than 120. These failures placed the Resident 2 at risk for hypoglycemia (low blood sugar level). 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]. Resident 2 was admitted with diagnoses including type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a slight paralysis or weakness on one side of the body). During a review of Resident 2's History and Physical (H&P) dated 10/10/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 2's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 2 required set-up and clean up assistance (helper sets up or cleans up; resident completes the activity) from staff for eating, maximal assistance (helper does more than half the effort) from staff for dressing and shower/bathing and was dependent (helper does all the effort) on staff for toileting. During a review of Resident 2's Care Plan dated 10/12/2025, the Care Plan Resident 2 had a diagnosis of DM. Under this Care Plan a goal for Resident 2 was to be free of all signs and symptoms of hypoglycemia. The Care Plan's interventions included for facility staff to administer hypoglycemic medications as ordered. During a review of Resident 2's Order Summary Report (Physician's Orders) dated 3/18/2026, the report indicated an order was placed for Resident 2 to receive glipizide oral tablet 2.5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) once a day for DM and hold if capillary blood glucose ([CBG] blood sugar) is less than 120, ordered on 3/4/2026. During a review of Resident 2's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2026 to 3/31/2026, the MAR indicated Resident 2's had the following CBG levels: 1. On 3/8/2026, Resident 2 had a CBG level of 98.2. On 3/10/2026, Resident 2 had a CBG level of 102.3. On 3/11/2026, Resident 2 had a CBG level of 100.4. On 3/13/2026, Resident 2 had a CBG level of 119.5. On 3/14/2026, Resident 2 had a CBG level of 117.6. On 3/15/2026, Resident 2 had a CBG level of 96.7. On 3/16/2026, Resident 2 had a CBG level of 101.8. On 3/17/2026, Resident 2 had a CBG level of 100. During a continued review of Resident 2's MAR dated 3/1/2026 to 3/31/2026, the MAR indicated Resident 2 received glipizide oral tablet 2.5 mg at 9 a.m. on 3/8/2026, 3/10/2026, 3/11/2026, 3/13/2026, 3/14/2026, 3/15/2026, 3/16/2026, and on 3/17/2026 despite having CBG levels less than 120. During a concurrent interview and record review on 3/18/2026 at 11:19 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 2's MAR dated 3/2026 was reviewed. LVN 3 acknowledged he had administered glipizide to Resident 2 outside of the parameters on multiple occasions. LVN 3 stated he was unaware Resident 2's glipizide order had parameters to hold the medication for a CBG less than 120. LVN 3 stated he was not familiar with glipizide having parameters, and he did not see the complete order when he administered the medication to Resident 2. LVN 3 stated he was off duty when the glipizide was ordered and stated if he had been on duty when the medication was received, he would have called the doctor to confirm the order since glipizide does not usually have parameters. LVN 3 stated he should not have assumed the medication (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>order did not have parameters and followed the doctor's order. LVN 3 stated Resident 2 could have become hypoglycemic from giving the glipizide outside of the parameters. During a concurrent interview and record review on 3/18/2026 at 1:04 p.m., with Registered Nurse (RN) 1, Resident 2's Order Summary Report, MAR, Nursing Progress Notes, and Change of Condition (COC) reports dated 3/2026 was reviewed. RN 1 confirmed glipizide was administered on multiple occasions when the CBG was less than 120. RN 1 stated nurses must check parameters before administering medications and follow physician orders. RN 1 further confirmed there was no documentation in the nursing progress notes or COC which reported the glipizide errors. During a telephone interview on 3/18/2026 at 4:17 p.m., with RN 2, RN 2 stated he took the telephone order for Resident 2's glipizide on 3/4/2025. RN 2 stated he repeated the order back to the physician to confirm the parameters, which included holding the medication for CBG less than 120. During a review of facility's P&P titled Medication Errors, dated 6/28/2022, the P&P indicated a medication error means the administration of medications to the wrong resident, at the wrong time, at the wrong dose, via the wrong route, or which is not currently prescribed.</p>		