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	01/31/2025

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 49145 Based on observation, interview, and record review, the facility failed to maintain resident dignity by failing to: 1.Ensure Resident 34 was provided with a privacy curtain. 2.Ensure Resident 45's urine collection bag was covered with a dignity or privacy bag. This failure had the potential to violate Resident 34 and Resident 45's rights to dignity and privacy. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including psychosis (severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and hypertension (high blood pressure). During a review of Resident 34's Minimum Data Set (MDS-resident assessment tool) dated 11/7/2024, the MDS indicated Resident 34 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 34 required substantial/maximal assistance with hygiene, shower/bathing, and dressing. During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), anxiety (a feeling of fear, dread, or uneasiness that can be normal reaction to stress), and depression (a constant feeling of sadness and loss of interest). During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 was cognitively intact. The MDS indicated Resident 45 was dependent (helper does all the effort) with Activities of Daily Living (ADL's- activities such as bathing, dressing, and toileting a person performs daily). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/2025 at 10:46 a.m., with Certified Nurse Assistant (CNA) 8, CNA 8 stated Resident 45's urine collection bag did not have a dignity or privacy bag in place. CNA 8 stated having a dignity or privacy bag is important to have in place for the dignity of the resident. During a concurrent observation and interview on 1/28/2025 at 10:14 a.m., the Housekeeping Supervisor (HS) was observed removing the privacy curtain in Resident 34's room. HS stated he is cleaning the curtains that are stained but there are no spare curtains to replace them while they are being cleaned. HS stated there should be a spare privacy curtain for the residents privacy and dignity. During an interview on 1/28/2025 at 12:30 p.m., with the Director of Nursing (DON), the DON stated there should be replacement curtains when the resident curtains are being cleaned for their dignity and privacy. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated, Each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain, and protect resident privacy. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents by helping the resident to keep the urinary catheter bags covered.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 49889 Based on observations, interviews and record reviews the facility failed to ensure Residents 16, 51 and 65 needs were provided for when: 1.Resident 16's call light was not functioning properly 2.Resident 16's, overhead light was missing the cord to turn it on and off 3.Resident 51's overhead light cord was not long enough for Resident 51 to reach it. 4.Resident 16 and 65's TV remotes did not have any batteries. 5.Resident 65's overbed table was not functioning properly. These failures resulted in Resident 16, 51, and 65 needs not provided to make comfortable and homelike environment. Findings: During a review of Resident 16's Admission Record, the admission record indicated Resident 16 was admitted on [DATE] with the diagnosis of femur (legs long bone), rib and humerus (long bone of the upper arm) fractures and a history of falling, and muscle weakness. During a review of Resident 16's Minimum Data Set ([MDS]- a resident assessment tool) dated 1/03/2025, the MDS indicated Resident 16 has the capacity to understand and make decisions. The MDS also indicated Resident 16 needed substantial/maximal assistance (helper does more than half the work) with toileting, bathing and upper and lower body dressing. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility 4/12/2023 with diagnoses including heart failure (heart unable to pump enough blood and oxygen to the body) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had moderate cognitive impairment and used a wheelchair for lower extremity impairment (part of your body is not working properly). During a review of Resident 65's Admission Record, the admission record indicated Resident 65 was admitted on [DATE] with the diagnosis including infection in the sacrococcygeal (lower end of the spine) region, muscle weakness and history of falling. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's MDS dated [DATE], the MDS indicated Resident 65 has the capacity to understand and make decisions. The MDS also indicated Resident 65 was dependent (helper does all the work) with toileting, bathing and lower body dressing. During an observation on 1/27/25 at 11:07 a.m. in Resident 16 and Resident 65's room 1.There were no batteries in their television remote controls. 2.Resident 16's overhead light did not have a cord to turn the light on and off. 3.Resident 65's bedside table did not roll properly and had trouble going up and down 4.The call light for both Resident 16 and Resident 65 was not functioning as it was not plugged into the outlet properly. During a concurrent observation and interview on 1/27/25 at 11:07 a.m. with Resident 16 in Resident 16's room, Resident 16 stated the call light was useless as it does not work. Resident 16 stated, her roommate has to turn the call light for her and the light above Resident 16's bed does not have a cord to turn it on or off. Resident 16 stated her TV remote control only has one battery. Resident 16 stated these issues gets her frustrated. During an interview on 1/28/2025 at 1:55 p.m., with Resident 51 during the Resident Council Meeting, Resident 51 stated when the facility painted his room, he was unable to turn his light above his bed by himself because the cord was short and could not reach it. Resident 51 stated it was frustrating because he must call and wait for the staff to come and turn his light on and off. During an interview on 1/27/25 at 11:02 a.m. with Resident 65 in Resident 65's room, Resident 65 stated the TV has not been working right since Resident 65 got to the facility. Resident 65 stated his overbed table does not roll either. Resident 65 stated he told the staff when he first arrived to his room. During a concurrent observation and interview on 1/27/2025 at 11:15 a.m. with Certified Nurse Assistant (CNA) 11 in Resident 16 and Resident 65's room, CNA 11 stated that Resident 16 and Resident 65's call light was not plugged into the wall properly. CNA 11 stated Resident 16's TV remote control had only one battery. CNA 11 stated that residents could fall if their call light was not working properly. CNA 11 stated resident should be able to watch TV if they want to. During an interview on 1/30/2025 at 11:15 a.m. with Licensed Vocational Nurse (LVN) 3, LVN3 stated that the TV in Resident 65 room was not working and that she had to turn the TV on manually for Resident 65. LVN3 stated residents should have TV that works because this is their home, and residents should be provided with a homelike environment. During an interview on 1/29/2025 at 11;15 a.m. with Infection Preventionist (IP), the IP stated that Resident 16's bedside table kept going up and would not stay down and did not roll properly. IP stated residents should be provided with working lights, working TV and bedside tables that are functioning properly as it affects their quality of life. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/27/2025 at 11:15 a.m. with CNA 6 in Resident 16 room and Resident 51, observed overhead cord to pull the light on and off was short and was not able to reach by Resident 51. CNA 6 stated it was important for the Resident 51 to have access to the light in case of emergency to see around and to provide a homelike environment. During an interview on 1/28/2025 at 3:08 p.m., with the Director of Nursing (DON), the DON stated access to lights provides safety, care and comfort for the resident. The DON stated Resident 16 and 51 not having access to their light cord can be frustrating for the residents. The DON stated that the TV remotes, bedside tables and call lights all needed to be working properly for the residents. The DON stated their quality of life can be affected. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, Residents are provided with a safe, clean, comfortable, and homelike environment. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable, and homelike environment to emphasize sufficient general lighting in resident-use areas and task lighting as needed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview and record review, the nursing staff failed to protect the resident's rights for one out of seven sampled residents (Resident 14) by not closing the privacy curtain to ensure Resident 14 would not be visually exposed to the roommates and others while the staff was doing personal care. This deficient practice violated Resident 14's right for privacy. Findings: During a record review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress). During a record review of Resident 14's History and Physical (H&P), dated 10/22/24, the H&P indicated, Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS a resident assessment tool), dated 12/26/2024, the MDS indicated, Resident 14 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunk or limbs and provides more than half the effort) with toileting, and personal hygiene. During an observation on 1/28/2025 at 8:54 a.m. while in hallway 3, Resident 14 lying in bed and exposed while CNA 11 was providing personal and repositioning her without the privacy curtain being drawn. During an interview on 1/28/25 at 8:56 a.m. with Certified Nurse Assistant (CNA 11), CNA 11 stated the privacy curtain should be closed when providing care to residents. CNA 11 stated by the privacy curtain being drawn it ensures the residents dignity and privacy is being maintained. CNA 11 stated the privacy curtain being open while providing personal care to Resident 14 could make her feel embarrassed. During an interview on 1/28/25 at 11:30 a.m. with License Vocational Nurse (LVN 5), LVN 5 stated that all the residents should be treated with dignity and respect. LVN 5 stated it is staff's responsibility when providing care to the residents to ensure that the privacy curtain is drawn so the residents are not being exposed. LVN 5 stated Resident 14 could feel embarrassed and ashamed from being exposed. During an interview on 1/28/25 at 3:16 p.m. with the Director of Nursing (DON), the DON stated facility staff are responsible for ensuring the residents' were treated with dignity and respect. The DON stated all staff should ensure that the residents' privacy curtains are drawn when providing care to the residents. DON stated if residents' are exposed it could cause the residents emotional distress. DON stated the residents deserve to be treated with dignity and respect at all times. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2021, the P&P indicated, Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During a review of the facility's P&P titled, Resident Rights, dated 2021, the P&P indicated, Employees shall treat all resident with kindness, respect, and dignity.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 45) right to be free from verbal abuse by Certified Nurse Assistant (CNA) 6 when he became verbally aggressive with Resident 45. This deficient practice resulted in Resident 45 being verbally abused by CNA 6 and had the potential for Resident 45 to feel unsafe and unprotected. Findings: During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), anxiety (a feeling of fear, dread, or uneasiness that can be normal reaction to stress), and depression (a constant feeling of sadness and loss of interest). During a review of Resident 45's Minimum Data Set (MDS- a resident assessment tool) dated 12/26/2024, the MDS indicated Resident 45 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 45 was dependent (helper does all the effort) with Activities of Daily Living (ADL's- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 37 Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (painful bone infection) and muscle weakness. During a review of Resident 37 MDS dated [DATE], the MDS indicated Resident 37 was cognitively intact. During an interview on 1/27/2025 at 2:00 p.m., with Resident 45, Resident 45 stated he overheard CNA 6 calling him a rat, and he replied to CNA 6 by calling CNA 6 faggot and telling him at least he does not stick d**ks up his a**. CNA 6 replied to Resident 45 by telling him he sticks enemas up his butt. Resident 45 stated CNA 6 told him he was going to beat him up when no one was around which made him feel scared. During an interview on 1/28/2025 at 3:53 p.m., with the Administrator (ADM), the ADM indicated when she interviewed CNA 6, he verbally confirmed that he told Resident 45 that he sticks enemas up his butt and told Resident 45 he needed to check himself. ADM stated CNA 6 verbally admitted that he was wrong in the way he spoke with Resident 45. During an interview on 1/29/2025 at 11:26 a.m., with the Director of Nursing (DON), the DON indicated CNA 6 and Resident 45 got into a verbal altercation on 1/16/2025. The DON stated CNA 6 admitted to making inappropriate comments to Resident 45 and his response to Resident 45 was wrong being Resident 45 is the resident being cared for and is disabled. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 12:15 p.m., with Resident 37, Resident 37 indicated he overheard the verbal altercation between CNA 6 and Resident 45. Resident 37 stated he overheard CNA 6 tell Resident 45 that he sticks enemas up his butt, and Resident 45 and CNA 6 then began cursing at one another. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, dated 10/25/2024, the P&P indicated, Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to a patient or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. During a review of the facility's P&P titled, Dignity, dated February 2021, indicated, Residents are treated with dignity and respect at all times. Staff speak respectfully to residents at all times. During a review of the facility's P&P titled, Resident Rights, dated 12/2021, indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be free from abuse, neglect, misappropriation of property, and exploitation

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 61) was free from unnecessary physical restraints (any object or device that an individual cannot remove easily which restricts freedom of movement) as evidenced by: 1.Resident 61's bed was against the wall on the right side with an upper side rail on the left side of the bed. This deficient practice had the potential to place Resident 61 at risk at risk for injury and potential for entrapment (event when an individual is trapped or entangled in the spaces of the bed rail). Findings: During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including encephalopathy (brain damage or disease that affects how the brain functions, and dementia (a progressive state of decline in mental abilities). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool) dated 12/23/2024, the MDS indicated Resident 61 was severely cognitively (ability to think, understand, learn, and remember) impaired. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) with eating, hygiene, and dressing. During a review of Resident 61's History and Physical (H&P) dated 9/19/2024, the H&P indicated Resident 61 does not have the capacity to understand and make decisions. During a concurrent observation and interview on 1/27/2025 at 10:46 a.m., with Certified Nurse Assistant (CNA) 8, CNA 8 stated Resident 61's bed was against the wall and the Resident 61 cannot get out easily. During a concurrent interview and record review on 1/28/2025 at 2:59 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 61's bed was against the wall but was unsure why. LVN 4 stated a resident's bed against the wall is considered a restraint and should be addressed in the care plan. LVN 4 stated there was no care plan for Resident 61's bed against the wall. During an interview on 1/28/2025 at 3:10 p.m. with the Director of Nursing (DON), the DON stated Resident 61's bed against the wall is considered a restraint because it inhibits movement for the resident. The DON stated if the resident prefers to have their bed up against the wall, the staff should ensure it is safe for the resident. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, undated, the P&P indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove the device in the same manner in which the staff applied it given that residents physical condition and this restricts his/her ability to change position or place, that device is considered a restraint.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to ensure a preadmission screening and annual review of a Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) was accurately documented for five of eight residents (Resident 5, 12, 17, 34, 46). This deficient practice had the potential to result in an inappropriate placement and delay of needed services for Resident's 5, 12, 17, 34, and 46. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (depressed mood causing significant impairment in daily life), and post-traumatic stress disorder (PTSD- unwanted memories of a trauma). During a review of Resident 5's (MDS- a resident assessment tool) the MDS dated [DATE], the MDS indicated Resident 5's cognition (ability to think, understand, learn, and remember) was intact. During a review of Resident 5's History & Physical (H&P) dated 4/5/24 indicated Resident 5 has the capacity to understand and make decisions. During review of Resident 5's Physician Order summary Report, dated 1/29/25, the Physician Order Summary report indicated, Resident 5 was taking abilify (a medication used to treat mental illness) psychosis (a mental disorder characterized by a disconnect from reality) and is on psychotropic (drugs that affect the brain and nervous system altering mood behavior, and cognitive function) medication. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are not so affected that contact is lost with reality) and hypertension (high blood pressure). During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 had severe cognitive impairment (someone with significant difficulty with thinking, remembering, making decisions, and understanding things). During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and major depressive disorder ([MDD]- a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 17's MDS dated [DATE], the MDS indicated Resident 17 had moderate cognitive impairment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was initially admitted to the facility 1/6/2023 and readmitted to the facility on [DATE] with diagnoses including psychosis and hypertension. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had moderate cognitive impairment. During a review of Resident 46's Admission Record, the Admission Record indicated Resident 46 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and major depressive disorder (MDD mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest). During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 had severe cognitive impairment. During a concurrent interview and record review on 1/29/2024 at 9:47 a.m., with Registered Nurse Supervisor (RNS) 2, reviewed PASSAR for Resident 5,12,17,34 and 46. RNS 2 stated Resident 5's PASARR Level I screening dated 7/11/2023, indicated a positive Level I screening. The PASARR level 1 screening indicated Resident 5 needed a PASARR level 11(Level II Mental Health Evaluation is required when the Level I screening result is positive screening). RNS2 stated that the PASARR level II was not done because Resident 5 was unable to participate in the evaluation and the case was now closed. RNS 2 stated Resident 5 has a diagnoses of depression, PTSD and psychosis and is on psychotropic (drugs that affect the brain and nervous system altering mood behavior, and cognitive function) medications. RNS2 stated Resident 12 has a diagnosis of psychosis and is prescribed a psychotropic medication but the PASARR Level I screening indicated Resident 12 did not have a mental illness. RNS 2 stated Resident 12 required a PASARR Level II screening but it was not done. RNS 2 stated Resident 17's PASARR Level I screening, dated 4/12/2016, indicated a negative Level I screening but should have been positive being Resident 17 had a diagnosis of mental illness. RNS 2 stated Resident 34 has a diagnosis of psychosis. RNS 2 stated Resident 34's PASARR Level I screening dated 8/17/2023, indicated PASARR Level I screening that Resident 34 had no mental illness. RNS 2 stated Resident 46's PASARR Level I screening, dated 4/5/2024, indicated a negative Level I. RNS 2 stated , Resident 46 had a diagnosis of mental illness. During an interview on 1/29/2025 at 9:47 a.m., with RNS 2, RNS 2 stated she was responsible for the completion of PASARR. RNS 2 stated she does not review the PASARR's when the resident is admitted to the facility. RNS 2 stated ensuring the PASARR is documented accurately is important to the residents so they receive the appropriate follow up and services they may need. RNS2 stated inaccuracy of the PASARR may affect the residents quality of care. During an interview on 1/29/2025 at 11:31 a.m., with the Director of Nursing (DON), the DON stated it was important to accurately document PASARR Level I to ensure the residents are in the appropriate setting and receive the special services they may need due to their diagnosis of mental illness. The DON stated the RNS is responsible for reviewing the PASARR's and ensuring they were completed accurately. During a review of the facility's policy and procedure (P&P) titled, PASARR Completion Policy, dated 9/30/2024, the P&P indicated, The Center will make sure that all admissions have the appropriate PASARR completed. (continued on next page)

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	055559	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Crest Care Center	3750 Garnet Street Torrance, CA 90503

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49889

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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** 49145 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person center care plan for two of four sampled residents (Resident 34 and Resident 61) by failing to: 1.Develop a comprehensive person-center care plan to address Resident 34 refusal of nail care and Resident 61's restraints. These failures had the potential to negatively affect the delivery of care and services to Residents 34 and 61. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was initially admitted to the facility 1/6/2023 and readmitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought,and emotions are so affected that contact is lost with reality), and hypertension (high blood pressure). During a review of Resident 34's MDS(MDS- a resident assessment tool) dated 11/7/2024, the MDS indicated Resident 34 had moderate cognitive (ability to think, understand, learn, and remember) impairment. During an interview on 1/27/2025 at 10:11 a.m., with Certified Nursing Assitant (CNA) 7, CNA 7 stated there is no specific place to document nail care but if the resident refuses, CNA 7 will notify her charge nurse. CNA 7 stated Resident 34 refuses to have his nails cleaned or trimmed but it is important to get it done because if not it can cause bacteria to develop under his nails and cause an infection especially when he scratch himself. During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including encephalopathy (brain damage or disease that affects how the brain functions), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61 had severe cognitive impairment. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) with eating, hygiene, and dressing. During a review of Resident 61's History and Physical (H&P) dated 9/19/2024, the H&P indicated Resident 61 does not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 61's care plan for communication initiated 12/27/2024, , the care plan indicated Resident 61 had impaired communication as evidenced by difficulty making self-understood and difficulty understanding others. The Care Plan goals included Resident 61 to demonstrate increased ability to understand others for 90 days. The care plan interventions for Resident 61 included validate meaning of non verbal communication and praise any efforts at communication attempts. During a concurrent observation and interview on 1/27/2025 at 10:46 a.m., with Certified Nurse Assistant (CNA) 8, CNA 8 stated Resident 61's bed is against the wall. During an interview on 1/28/2025 at 12:28 p.m., with the Director of Nursing (DON), the DON indicated when a resident refuses care, the doctor should be notified, and a care plan should be implemented so it can be followed up with by the staff. The DON stated Resident 61's bed against the wall is considered a restraint because it inhibits movement for the resident. The DON stated there should be an order and a care plan should have been developed. The DON stated if a resident prefers to have their bed against the wall, the care plan should reflect this. During a concurrent interview and record review on 1/28/2025 at 1:33 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated there was no physician order or care plan for Resident 61's bed against the wall. LVN 4 stated for the safety of the resident, there should be a physician order, and a care plan should have be implemented. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 3/28/2024, the P&P indicated, Each resident's comprehensive care plan is designed to: build on the resident's individualized needs, strengths, preferences; reflect the resident's expressed wishes regarding care and treatment goals. During a review of the facility's P&P titled, Use of Restraints, undated, the P&P indicated, Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.

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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** 45537 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 69) care plan interventions for risk of fall was revised and updated after Resident 69 had a fall. Resident 69 had fallen five times (12/19/2024, 1/2/2025, 1/7/2025, 1/9/2025 and 1/26/2025) in the facility. On 1/7/2025, the Interdisciplinary Team (IDT) indicated a recommendation from a licensed nurse for Resident 69 to have a sitter to provide assistance, supervision and close monitoring, with the IDT recommendation to revise the care plan and update to prevent recurrence. This deficient practice has resulted to a fourth and fifth fall of Resident 69 on 1/9/2025 and 1/26/2025. Findings: During a review of Resident 69's Admission Record , the Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disturbance in the brain function that causes confusion, memory loss and coma in severe cases), dementia (a condition when a person losses cognitive [relating to mental processes of perception, memory, judgment and reasoning] functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities), generalized weakness and history of falls. During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool) dated 1/6/2025, the MDS indicated Resident 69 was able to make decisions that were reasonable. The MDS indicated Resident 69 required one person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as transferring from chair/bed-to-chair, toilet transfer and ambulation (the ability to walk from place to place independently, with or without assistive devices), and was incontinent (loss of control) of bladder and bowel functions. During a review of Resident 69's care plan titled Risk for falls related to impaired mobility (ability to move purposefully through one's daily life), weakness, dementia, psychosis (a disorder when people lose contact with reality ., the care plan indicated interventions included were to assist Resident 69 in getting in and out of bed, provide verbal cues for safety, and energy conservation techniques (practices and methods aimed at reducing energy consumption by using less energy overall), remind Resident 69 to use the call light for assistance, monitor and assist for toileting needs and encourage Resident 69 to attend activities to maximize full potential while socializing. During a review of Resident 69's Nursing Documentation dated 12/18/2024 timed at 2:55 p.m., the Nursing Documentation indicated Resident 69 was assessed on admission with poor safety judgement, confusion and forgetfulness, weak to lower extremities which required Resident 69 to use a wheelchair as assistive device. The Nursing Documentation indicated Resident 69 was identified as a risk of fall due to history of falls in the last six months, disorientation/confusion, poor safety judgement, requiring assistance during toileting and a prescribed cardiac (heart) medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 69's COC dated 1/7/2025 timed at 7:07 a.m., the COC indicated Resident 69 was repeatedly getting out of the bed and the roommate stated Resident 69 had a fall (not specified). The COC indicated Resident 69 was observed to sustain a cut on his head. The COC indicated recommendations included to have a sitter (healthcare workers responsible for constant observation of patients at risk for falling) to assist and supervise Resident 69. During a review of Resident 69's IDT notes: Fall Incident on 1/7/2025 at 10:45 a.m. the IDT notes indicated Resident 69 had a fall on 1/7/2025 at 7:07 a.m. as witnessed by Resident 69's roommate. The IDT notes indicated licensed nurse (unknown) recommended a sitter for Resident 69 to assist and supervise Resident 69. The IDT Notes indicated the risk factors of Resident 69's fall was because of confusion, impaired balance, unsteady gait, poor safety awareness, not calling for assistance and history of falls within the last 30 days. The IDT Notes indicated the IDT recommendations was for Rehab department to give recommendations, and to revised and update the care plan to prevent recurrence of fall. During a review of Resident 69's care plan on Risk for falls dated 12/18/2024, the care plan did not indicate any revision on Resident 69's fall risk interventions and safety precautions, after Resident 69 had a fall on 1/7/2025. During a review of Resident 69's COC dated 1/9/2025 timed at 11:14 p.m. the COC indicated Resident 69 had a fall incident (details not specified). The COC indicated Resident 69 was in pain (location not specified) due to a previous fall with vital signs (the values that reflect the essential functions of the body) of blood pressure 119/65 mmHg, heart rate of 105 beats per minute, respiratory rate of 16, temperature of 97.3 Fahrenheit (F a unit of measurement that is used to measure temperature) and oxygen saturation (the amount of oxygen circulating in the blood) of 88% (not specified if room air or with oxygen supplement). The COC indicated if Resident 69's condition worsen, to transfer Resident 69 to GACH. During a review of Resident 69's care plan on Risk for falls dated 12/18/2024, the care plan did not indicate any revision on Resident 69's fall risk interventions and safety precautions, after Resident 69 had a fall on 1/9/2025. During a review of Resident 69's COC documented on 1/26/2025 at 10:36 p.m. indicated Resident 69 was observed by the Licensed Vocational Nurse (LVN)2 came out of his room and Resident 69's feet crossed resulting to Resident 69 fell on his buttocks in the hallway outside his room. During a concurrent observation and interview on 1/27/2025 at 4 p.m., with Resident 69, Resident 69 stated on 1/27/2025 morning (7 a.m. to 3 p.m. shift) nursing assistant (unknown) did not listen to him when he requested to get out of bed. Resident 69 was observed in his room with no sitter. Observed on 1/27/2025 at 12:18 p.m., 2 p.m. and 4 p.m. with no staff who constantly and/or frequently checked on Resident 69's needs and care. During an observation on 1/28/2025 at 3 p.m., Resident 69 was observed napping in his room and there was no sitter at the bedside. Observed on 1/28/2025 at 9:30 a.m., 10:30 a.m., 12 p.m., 1:30 p.m., and 3 p.m., with no staff who constantly and/or frequently checked on Resident 69's needs and care. During an observation and interview on 1/29/2025 at 11:40 a.m., with Resident 69, Resident 69 was observed in bed napping. Resident 69 stated there was no staff who stayed with him in his room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/29/2025 at 12:37 p.m., with Registered Nurse Supervisor 2 (RNS 2). RNS2 stated Resident 69's plan of care has not been revised and updated since 12/19/2024. RNS 2 stated the care plan interventions did not indicate recommendations made by the IDT on 1/7/2025 which include Resident 69 need for close monitoring and frequent visual checks and a sitter. (sitter). RNS 2 stated Resident 69's care plan should be revised/updated according to the residents' change of condition. RNS 2 stated fall risk safety precautions must be discussed amongst the nursing staff to ensure the right interventions was in place to prevent repeated falls and risks of injury. During an interview on 1/29/2025 at 1:30 p.m., with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated he received a report during the huddle (a short stand-up meeting at the start of the shift to discuss residents' needs) to keep an eye on Resident 69 because of Resident 69's fall risk. CNA 5 stated he tried to do visual check on Resident 69 every two hours. CNA 5 stated it was hard to do because he takes a lot of time with the other residents. During an interview on 1/30/2025 at 2:22 p.m., the Director of Nursing Services (DON) stated all residents at the facility are considered high risk for fall and a fall and/or associated injury to a fall is avoidable/ preventable. During a review of the facility's policy and procedures (P&P) titled Care Plan Comprehensive revised 3/28/2024, the P/P indicated each resident of the facility will have an individualized comprehensive care plan that includes measurable objectives and timetables to meet each resident's needs to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being. The P/P indicated the following: 1. the residents' identified problem areas, risk and contributing factors associated with the identified problems, treatment goals, timetables and objectives in measurable outcomes shall be incorporated in the residents' care plan. 2. the residents' areas of concern triggered during the resident assessment are evaluated using specific assessment tools and care plan interventions are designed, revised and updated after careful consideration of the relationship between the resident's problem areas and their causes. 3. the assessments of the residents are ongoing and care plans are reviewed and revised as information about the residents and residents' condition change. Cross Reference F689

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 69) was assisted to get out of bed to perform his activities of daily living and enjoy his preferred activities. This failure had the potential for Resident 69 to decline in his mobility and negatively affect his psychosocial well-being. Findings: During a review of Resident 69's Admission Record , the Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disturbance in the brain function that causes confusion, memory loss and coma in severe cases), dementia (a condition when a person losses cognitive [relating to mental processes of perception, memory, judgment and reasoning] functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities), generalized weakness and history of falls. During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool) dated 1/6/2025, the MDS indicated Resident 69 was able to make decisions that were reasonable. The MDS indicated Resident 69 required one person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as transferring from chair/bed-to-chair, toilet transfer and ambulation (the ability to walk from place to place independently, with or without assistive devices), and was incontinent (loss of control) of bladder and bowel functions. During a review of Resident 69's care plan titled At risk for decreased ability to perform ADLs dated 12/18/2024 related to illness, fall, hospitalization , impaired balance and limited mobility, the care plan indicated a goal for Resident 69 ADLs care needs to be anticipated. The care plan interventions included to provide cueing (the act of giving a clue or prompt to another person) for safety and sequencing (the process of combining things in a particular order) to maximize his level of function, to provide Resident 69 with one to two persons assist during bed mobility and transfers and to monitor Resident 69's decline in function. During a concurrenet observation and interview with Resident 69, the following were observed: 1. On 1/27/2025 at 2 p.m., Resident 69 was observed lying in 45 degrees head of bed elevation in bed and stated he was tired of watching television, and just wanted to take a nap because the nursing staff did offer to get him out of bed. 2. On 1/27/2025 at 4 p.m., Resident 69 stated he asked the nursing staff to help him get out of bed to sit on his wheelchair but the nursing staff did not help him. 3. On 1/28/2025 at 9:30 a.m., Resident 69 stated he wanted to get up today but the nursing staff told him to stay in bed. Resident 69 stated he wanted to sit up on his wheelchair to go outside and talk to other people. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 1/28/2025 at 10:30 a.m., Resident 69 was awake in his bed and was looking at the hallway outside his room. 5. On 1/28/2025 at 2 p.m., Resident 69 was in bed taking a nap. 6. On 1/29/2025 at 9:30 a.m., Resident 69 was awake in bed and looking at the hallway outside his room. 7. On 1/29/2025 at 10:04 a.m., resident 69 stated he would love to get out of bed but decided not to ask anymore because he was afraid the nursing staff would tell him why he is trying/wanting to get up. Resident 69 stated the nursing staff would always tell him that he is supposed to be in bed and he felt he did not have the freedom to do the things he wanted to do. Resident 69 stated he was worried he was always in bed and he might get weaker. 8. On 1/29/2025 at 11:28 a.m., Resident 69 was still in his bed with a bored expression on his face and stated the nursing staff did not offer to help him to get out of bed and sit on his wheelchair. During an interview on 1/29/2024 at 11:40 a.m.,with Certified Nursing Assistant 5 (CNA 5) CNA 5 stated it was the responsibility of the nursing assistants assigned to the residents to offer assistance to get up from the bed and sit on their chairs (wheelchairs), as part of the residents' ADL care. CNA 5 stated the residents can get sicker and depressed if they are not assisted with their ADLs and encouraged to enjoy the activities of their choice. During an interview on 1/29/2024 at 12:08 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated it was necessary for the residents to be assisted and/or supervised to get out of bed and perform their other daily tasks to prevent decline on their mobility and function and complications of weakness and contractures (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). During an interview on 1/29/2025 at 4 p.m., with the Director of Nursing Services (DON), the DON stated assisting the residents to get out of bed and attend their activities of choice is part of ADL care and should be offered and/ or encouraged to promote a quality of life. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting revised 3/2018, the P&P indicated the residents of the facility will be provided care, treatment and services to ensure their activities of daily living (ADLs) do not diminish. During a review of the facility's P&P titled, Quality of life-Accommodation of Needs revised 8/2009, the (P&P) indicated the facility's environment and staff behavior should be directed toward assisting the residents in maintaining and/or achieving independent functioning, dignity and well-being by ensuring the resident's individual needs and preferences shall be accommodated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure five of five sampled residents (Resident 6, 69, 13, 34 and 68) fingernails were trimmed and free from accumulation of unknown substances underneath their fingernails. This failure has resulted to Resident 6, 69 , 13, 34 and 68 fingernails to have irregular edges, accumulation of dark brown substance under the fingernails and had the potential to cause infection and impaired skin integrity. Findings: A. During a record review of Resident 6's Admission Record ,the Admission record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (a serious condition where the blood glucose is too high), major depressive disorder (a mental health condition that causes people to feel extremely sad, frustrated, angry, and unable to enjoy life and sleep because of low energy or mental focus) and generalized muscle weakness. During a review of Resident 6's Minimum Data Set (MDS a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 6 was unable to make decisions that were consistent and dependent to two or more person to complete her activities of daily living (ADLs- routine tasks/activities such as bathing, toileting and personal hygiene. During a review of Resident 6's care plan on risk for decreased ability to perform ADLs dated 8/5/2023, the care plan indicated Resident 6 was unable to perform her ADLs such as bathing, grooming, personal hygiene, dressing, eating, transfer and bed mobility due to pain and decreased strength, balance, and functional activity tolerance. The goal of the care plan was for Resident 6 to perform ADLs with supervision with interventions including to provide Resident 6 with extensive assistance with two to three persons assist during bathing, toileting and personal hygiene and to monitor Resident 6 for decline in ADL function. During an observation and interview on 1/27/2025 at 12:02 p.m., Resident 6 showed her fingernails and her fingernails were untrimmed with some dark brown deposits underneath the nails. Resident 6 stated she did not like the way her fingernails looked because they were long, unclean and no one in the facility has been provided nail care to her. B. During a review of Resident 69's Admission Record , the Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disturbance in the brain function that causes confusion, memory loss and coma in severe cases), dementia (a condition when a person losses cognitive [relating to mental processes of perception, memory, judgment and reasoning] functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities), generalized weakness and history of falls. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's MDS dated [DATE], the MDS indicated Resident 69 was able to make decisions that were reasonable. The MDS indicated Resident 69 required one person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as transferring from chair/bed-to-chair, toilet transfer and ambulation (the ability to walk from place to place independently, with or without assistive devices), During an observation and interview on 1/27/2025 at 12:18 p.m., Resident 69 showed his fingernails and stated he was not happy about how his fingernails look because they were untrimmed and have dark brown deposits underneath his fingernails. Resident 69 stated the nursing staff of the facility should be able to do their job by cleaning his fingernails. C. During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnosis including Parkinson's disease (a condition where a part of the brain deteriorates, causing severe symptoms over time that affects muscle control, balance and movement) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 was unable to make decisions that were consistent and required dependent to two or more persons assist to complete her ADL's routine tasks/activities such as bathing, toileting and personal hygiene. During a review of Resident 13's care plan on at risk for decreased ability to perform ADLs in bathing, grooming, and personal hygiene dated 9/16/2021, the care plan indicated Resident 13 had decreased ability to perform her ADLs related to Parkinson's disease and major depressive disorder. The goal of the care plan was for Resident 13's ADLs care needs to be anticipated. The care plan indicated no specific interventions on how the nursing staff should assist Resident 13 with her ALDs. During an observation and interview on 1/27/2025 at 12:43 p.m., Resident 13's fingernails were long with irregular edges and there was accumulation of dark brown substances under [NAME] her fingernails. Resident 13, while looking at her fingernails, stated with an unhappy expression on her face, that her fingernails are unclean and untrimmed. During an interview on 1/27/2025 at 12:57 p.m., with Certified Nursing Assistant 1 (CNA 1) CNA 1 stated that CNAs are supposed to perform nail care after each resident's bath or shower. CNA 1 stated the residents could accidentally scratch themselves and cause an injury to their skin if their fingernails are not trimmed and could cause them to be exposed to infection if their fingernails are unclean. D. During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was initially admitted to the facility 1/6/2023 and readmitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and hypertension (high blood pressure). During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 34 required substantial/maximal assistance with hygiene, shower/bathing, and dressing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Crest Care Center	3750 Garnet Street Torrance, CA 90503

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's care plan initiated 3/16/2023, the care plan focus was, Resident 34 is at risk for skin breakdown related to frail (weak, unhealthy, or easily damaged) fragile (breaks easily) skin with goals that included Resident 34's skin will be intact. Interventions for Resident 34 included to provide preventative skin care and observe skin for signs/symptoms of skin breakdown. E. During a review of Resident 68's Admission Record, the Admission Record indicated Resident 68 was admitted to the facility 11/1/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hypertension. During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68 was cognitively intact. The MDS indicated Resident 68 required partial/moderate assistance (helper does less than half the effort) with toileting, showering/bathing, and dressing. During an interview on 1/27/2025 at 10:11 a.m., with CNA 7, CNA 7 stated there is no specific place to document nail care but if the resident refuses, CNA 7 will notify her charge nurse. CNA 7 stated Resident 34 refuses to have his nails cleaned or trimmed but it is important to get it done because if not it can cause bacteria to develop under his nails and cause an infection especially when he scratch himself. During an interview on 1/27/2025 at 2:36 p.m., with Activities Assistance (AA), the AA stated Resident 68's fingernails were long, jagged, and dirty and they should be trimmed and cleaned. The AA stated long, and unclean fingernails can cause an infection for Resident 68 being he is able to feed himself. During an interview on 1/27/2025 at 1:04 p.m., the Director of Staff Development (DSD) stated the CNAs are supposed to clean and trim the residents' fingernails during ADL care and as needed to ensure they are free from injuries and free from infection. The DSD stated nail care is part of personal hygiene and should not be missed. During an interview on 1/27/2025 at 12:29 p.m., with the Director of Nursing Services (DON), the DON stated the residents should be provided with care and services such as ADL's assistance in a timely manner to prevent the residents from feelings of discomfort and to prevent them from incurring complications of infection and skin injuries related to untrimmed and unclean fingernails. During an interview on 1/28/2025 at 12:28 p.m., with the Director of Nursing (DON), the DON stated if a resident refuses to have their nails clipped it should be documented and care planned so it can be followed up. The DON stated when a resident's nails are not clean and trimmed, it could potentially lead to an infection, injury from scratching themselves, discomfort, or negatively impact their dignity. During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting 3/2018, the P&P indicated the residents of the facility who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming and personal/oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Fingernails/Toenails, Care of, dated 2/2018, the P&P indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 49145

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure the residents, who were assessed as high risk for falls, were free from fall accidents for one of four sampled residents (Resident 69). The facility failed to: 1. Conduct fall risk re-assessment after each Resident 69's fall. 2. Evaluate and revise Resident 69's care plan after each fall to evaluate the current preventative measures effectiveness and to develop new measures. 3. Conduct evaluation of Resident 69's condition after the falls and to follow 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) recommendations to provide a sitter for Resident 69. 4. Implement the facility's policy and procedure (P&P) titled Fall Management, revised 3/28/2024 which indicated the facility will ensure the residents will have reduced risk for falls and falls recurrence will be minimized. The residents will be assessed for fall risk as part of the nursing assessment process to determine the residents' risk thereby providing the residents with appropriate interventions, based on their individualized care plan, to reduce the risk and minimize injury. These deficient practices had resulted in 1. Resident 69 having falls on 1/2/2025, 1/7/2025 and 1/9/2025 with skin abrasion and cuts. Findings: During a review of Resident 69's Admission Record , the Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disturbance in the brain function that causes confusion, memory loss and coma in severe cases), dementia (a condition when a person losses cognitive [relating to mental processes of perception, memory, judgment and reasoning] functioning such as thinking, remembering, and reasoning to such extent that it interferes with a person's daily life and activities), generalized weakness and history of falls. During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool) dated 1/6/2025, the MDS indicated Resident 69 was able to make decisions that were reasonable. The MDS indicated Resident 69 required one person assistance to complete his activities of daily living ([ADLs] routine tasks/activities such as transferring from chair/bed-to-chair, toilet transfer and ambulation (the ability to walk from place to place independently, with or without assistive devices), and was incontinent (loss of control) of bladder and bowel functions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's care plan titled, At risk for decreased ability to perform ADLs related to illness, fall, hospitalization , impaired balance and limited mobility dated 12/18/2024, the care plan indicated a goal to anticipated Resident 69's ADLs care needs. The care plan interventions included to provide cueing (the act of giving a clue or prompt to another person) for safety and sequencing (the process of combining things in a particular order) to maximize his level of function, to provide Resident 69 with one to two persons assistance during bed mobility and transfers, and to monitor Resident 69's decline in function. During a review of Resident 69's care plan titled, Risk for falls related to impaired mobility (ability to move purposefully through one's daily life), weakness, dementia, psychosis (a disorder when people lose contact with reality), the care plan indicated the interventions included to assist Resident 69 in getting in and out of bed, provide verbal cues for safety and energy conservation techniques (practices and methods aimed at reducing energy consumption by using less energy overall), remind Resident 69 to use the call light for assistance, monitor and assist with toileting needs, and encourage Resident 69 to attend activities to maximize full potential while socializing. During a review of Resident 69's Nursing Documentation dated 12/18/2024 and timed at 2:55 p.m., the Nursing Documentation indicated on admission Resident 69 was assessed to have poor safety judgement, confusion, and forgetfulness. The Nursing Documentation indicated Resident 69 had weak lower extremities which required Resident 69 to use a wheelchair as an assistive device. The Nursing Documentation indicated Resident 69 was identified as a risk of fall due to history of falls in the last six months, disorientation/confusion, poor safety judgement, need for assistance with toileting and prescribed cardiac (heart) medication. During a review of Resident 69's Change of Condition (COC) dated 1/2/2025 and timed at 12 a.m., the COC indicated Resident 69 had dry blood to the forehead and complained of blurry vision and dizziness. The COC indicated Resident 69's blood pressure was 174/74 (the reference range of systolic blood pressure is120 millimeters of mercury [mm Hg]) and diastolic (the blood pressure in the arteries when the heart is at rest between beats) pressure of less than 80 mmHg, and the heart rate was 104 beats per minute (the reference range is 60 to 100 beats per minute). The COC indicated paramedics (a person trained to give emergency medical care to people who are injured or ill) were called and Resident 69 was transferred to a GACH for evaluation and discharged back to the facility on the same day (1/2/2025) with a discharge diagnosis of abrasion to the head due to fall. During a review of Resident 69's IDT Care Conference Notes titled, Fall Incident' dated 1/3/2025, and timed at 10:54 a.m., the IDT Care Conference Notes indicated Resident 69 had a fall on 1/2/2025 at 12 a.m. The IDT Note indicated the risk factors of Resident 69's fall included confusion, impaired balance, unsteady gait, poor safety awareness, not calling for assistance and falls within the last 30 days. The IDT Note indicated Resident 69 stated he got up unassisted from bed, stood up, and lost his balance. The IDT Noted indicated IDT recommended for Rehabilitation (Rehab-a process that helps people regain their abilities after an injury or illness) department to give recommendations, revise, and update care plan to prevent recurrence of falls. During a review of Resident 69's COC dated 1/7/2025 timed at 7:07 a.m., the COC indicated Resident 69 roommate stated Resident 69 was repeatedly getting out of the bed and fell (not specified). The COC indicated Resident 69 was observed to have a cut on his head (unspecified location). The COC indicated IDT recommendations included to have a sitter (healthcare workers responsible for constant observation of patients at risk for falling) to assist and supervise Resident 69. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's IDT Fall Incident Notes dated 1/7/2025 at 10:45 a.m. the IDT Notes indicated Resident 69 had a fall on 1/7/2025 at 7:07 a.m. witnessed by Resident 69's roommate. The IDT Notes indicated the licensed nurse (unknown) recommended a sitter to assist and supervise Resident 69. The IDT Notes indicated the risk factors of Resident 69's fall included confusion, impaired balance, unsteady gait, poor safety awareness, not calling for assistance and history of falls within the last 30 days. The IDT Notes indicated the IDT recommendations were for Rehab department to give recommendations, and to revised and update the care plan to prevent recurrence of fall. During a review of Resident 69's COC dated 1/9/2025 timed at 11:14 p.m. the COC indicated Resident 69 had a fall incident (details not specified). The COC indicated Resident 69 was in pain (location not specified) due to a previous fall. The COC indicated Resident 69's vital signs (the values that reflect the essential functions of the body) were as follows: blood pressure 119/65 mmHg, heart rate of 105 beats per minute, respiratory rate of 16 (a normal respiratory rate for an adult at rest is 12 to 20 breaths per minute), temperature of 97.3 Fahrenheit (F a normal range from 97.8 F to 99 F) a unit of measurement that is used to measure temperature) and oxygen saturation (the amount of oxygen circulating in the blood) of 88% (not specified if room air or with oxygen supplement [normal range between 95% and 100%.]). The COC indicated if Resident 69's condition gets worse to transfer Resident 69 to the GACH. During a review of Resident 69's IDT Fall Incident Notes dated 1/10/2025 and timed at 10:12 a.m., the IDT Fall Incident Notes indicated Resident 69 had an unwitnessed fall and was found on the floor by a Certified Nursing Assistant (CNA-unknown). The IDT Fall Incident Notes indicated Resident 69 sustained a cut on the left eyebrow. The IDT Fall Incident Notes indicated the risk factors of Resident 69's fall included confusion, impaired balance, unsteady gait, poor safety awareness and not calling for assistance. The IDT Fall Incident Notes indicated IDT's recommendations for Rehab department to give recommendations, to revised and update care plan to prevent recurrence and transfer Resident 69 to GACH for evaluation if his condition will get worse. During a review of Resident 69's Case Manager Progress Notes dated 1/13/2025, and timed at 5:51 p.m., the Case Manager Progress Notes indicated Resident 69's primary care physician gave an order for Resident 69 to be transferred to the GACH for evaluation due to dizziness and seeing floaters (spots in vision that looks like black or gray specks across the eyes). During a review of Resident 69's GACH Emergency Department (ED) Notes dated 1/13/2025 and timed at 9:46 p.m., the ED Notes indicated Resident 69 was seen at the emergency room for visual issues lights flashing with three episodes of falling over the past week (1/2/2025, 1/7/2025 and 1/9/2025). The ED Notes indicated Resident 69 was admitted to the GACH with the impression of unsteady gait and repeated falls. During a review of Resident 69's Nursing Documentation dated 1/20/2025 and timed at 5:49 p.m., the Nursing Documentation indicated Resident 69 was readmitted to the facility on [DATE] with poor safety judgement, non-compliance, confusion forgetfulness, and weakness to lower extremities. The Nursing Documentation indicated Resident 69 required to use a wheelchair as assistive device. The Nursing Documentation indicated Resident 69 was identified as a risk of fall due to history of falls in the last 6 months (five falls), disorientation/confusion, poor safety judgement, requiring assistance during toileting and a prescribed cardiac medication. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's COC documented on 1/26/2025 at 10:36 p.m., the COC indicated Licensed Vocational Nurse (LVN)2 observed Resident 69 coming out of his room, had his feet crossed resulting in Resident 69's fall on his buttocks in the hallway outside his room. During a review of Resident 69's Nursing Assessments And Progress Notes documentation, the Nursing Assessment And Progress Notes did not indicate Resident 69 was reassessed for fall risk and there was a post (after) fall assessment done after each Resident 69 fall on 1/2/2025, 1/7/2025, 1/9/2025 and 1/26/2025. During a review of Resident 69's care plan titled, Risk for falls dated 12/18/2024, the care plan indicated there was no re-evaluation of fall risk prevention interventions and safety precautions done after each Resident 69's fall, on 1/2/2025, 1/7/2025,1/9/2025 and 1/26/2025. During a concurrent observation and interview on 1/27/2025 at 4 p.m., Resident 69 stated that on 1/27/2025 morning (7 a.m. to 3 p.m. shift) nursing assistant (unknown) did not listen to him when he requested to get out of bed. Resident 69 was observed in his room with no sitter present. During the observation on 1/27/2025 at 12:18 p.m., 2 p.m. and 4 p.m., Resident 69 was observed in his room with no sitter present to constantly and/or frequently checked on Resident 69's needs and care per IDR recommendation During an observation on 1/28/2025 at 3 p.m., Resident 69 was observed napping in his room and there was no sitter at the bedside. On 1/28/2025 at 9:30 a.m., 10:30 a.m., 12 p.m., 1:30 p.m., and 3 p.m., Resident 69 was observed with no sitter present who had to frequently checked and monitor Resident 69's needs and care to prevent falls During an observation and interview on 1/29/2025 at 11:40 a.m., Resident 69 was observed in bed napping. Resident 69 stated there was no sitter who was staying with him in his room. During an interview on 1/29/2025 at 12:08 p.m., Licensed Vocational Nurse 2 (LVN 2) stated Resident 69 was able to verbalize his needs, however, was unsteady during walking and had episodes of getting out of bed without asking for assistance. LVN 2 stated Resident 69 had fallen five times within the past two months (12/18/2024, 1/2/2025, 1/7/2025, 1/9/2025 and 1/26/2025). LVN 2 stated she assessed Resident 69 and completed a COC after each resident's fall. LVN 2 stated she did not conduct Resident 69's fall risk reassessment nor documented a post fall assessment after each Resident 69 fall. LVN 2 stated it was important to reassess Resident 69's fall risk after each fall to determine if the resident's fall risk category has changed and if care plan interventions need to be revised to ensure the right safety precaution/supervision was implemented. LVN 2 stated repeated falls can cause injury to the residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/29/2025 at 12:37 p.m., with Registered Nurse Supervisor 2 (RNS 2) the RNS 2 stated there was no fall risk reassessments and post fall assessments documented in Resident 69's medical record after Resident 69's fall on 12/18/2024,1/2/2025,1/7/2025, 1/9/2025 and 1/26/2025. RNS 2 stated Resident 69's plan of care has not been revised and updated since 12/19/2024. RNS 2 stated the care plan interventions did not indicate recommendations made by the IDT on 1/7/2025 which included Resident 69 need for close monitoring, frequent visual checks, and a sitter. RNS 2 stated on 1/7/2025 Resident 69 was transferred to another room with a sitter for another resident. RNS 2 stated the sitter was watching two rooms. RNS 2 stated when Resident 69 returned from the GACH on 1/20/2025 Resident 69 was placed in another room with no sitter. RNS 2 stated Resident 69's care plan should have been revised/updated according to the residents' change of condition. RNS 2 stated fall risk safety precautions must be discussed amongst the nursing staff to ensure the right interventions was in place to prevent repeated falls and risks of injury. During an interview on 1/29/2025 at 1:30 p.m., with Certified Nursing Assistant 5 (CNA 5), the CNA 5 stated he received a report during the huddle (a short stand-up meeting at the start of the shift to discuss residents' needs) on 1/29/2025 to keep an eye on Resident 69 because of Resident 69's fall risk. CNA 5 stated he tried to visually check Resident 69 every two hours. CNA 5 stated it was hard to do because he (CNA 5) takes a lot of time with the other residents. During an interview on 1/29/2025 at 2:25 p.m., with the Director of Rehabilitation Services (DOR), the DOR stated Resident 69 was forgetful with poor safety awareness, was unsteady when walking and attempted to get up unassisted resulting in five falls incidents (12/18/2024,1/2/2024,1/7/2025,1/9/2025 and 1/26/2025). The DOR stated the facility conducts an IDT meeting after each fall to discuss the risk factors of the fall and then follow the IDT recommendation with a goal and interventions to prevent fall recurrence. The DOR stated she only performs a rehabilitation screening (a review of a patient's medical records and other information to determine if they may benefit from rehabilitation) for resident (in general) after a fall incident. During an interview on 1/30/2025 at 2:22 p.m., the Director of Nursing Services (DON) stated all residents at the facility are considered high risk for fall. The DON stated falls and/ injuries due to a fall are avoidable and preventable. During a review of the facility's P&P titled, Fall Management revised 3/28/2024, the P&P indicated the facility will ensure the residents will have reduced risk for falls, actual occurrence of falls minimized, injuries addressed incurred after a fall and care provided for a fall. The P&P indicated the residents will be assessed for fall risk as part of the nursing assessment process to determine the residents' risk thereby providing the residents with appropriate interventions, based on their individualized care plan, to reduce the risk and minimize injury. 49145

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981 Based on observation, interview, and record review, the facility staff failed to ensure one of 7 sampled residents (Resident 33) received two liters of oxygen continuously according to physician's order. This deficient practice had the potential to cause complications associated with oxygen therapy. Findings: During a record review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) and hypoxia (low levels of oxygen in your body tissues). During a record review of Resident 33's History and Physical (H&P), dated 1/9/25, the H/P indicated Resident 33 had fluctuating capacity to understand and make decisions. During a record review of Resident 33's Minimum Data Set (MDS, a resident assessment tool), dated 1/2/25, The MDS indicated, Resident 33 required substantial/maximal assistance (Helper doe more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting, and personal hygiene. During a concurrent observation and interview on 1/27/25 at 10:12 a.m. with Resident 33 in her room, Resident 33 was receiving oxygen 1.5 liters via nasal cannula ([n/c] a small, flexible tube with two prongs that fit inside your nostrils, used to deliver supplemental oxygen directly into your nose). Resident 33 stated that she should be receiving 2 liters of oxygen. During a concurrent observation and interview on 1/27/25 at 11:12 a.m. with License Vocational Nurse (LVN 5), LVN 5 stated Resident 33 is receiving continuous oxygen due to low oxygen saturation levels (a measurement of how much oxygen the blood is carrying as a percentage). LVN 5 stated that all license staff are responsible for the administration and maintenance of oxygen LVN 5 stated that it is important to ensure that Resident 33 is receiving the correct amount of oxygen which is 2 LPM because her oxygen levels could go down which could cause her to become hypoxic (low levels of oxygen in your body tissues). LVN 5 stated Resident 33 could have respiratory distress (difficulty breathing, where someone has trouble getting enough air into their lungs) or respiratory failure (a medical condition where the lungs are unable to effectively exchange oxygen) if she does not receive the correct amount of oxygen and possibly stop breathing. During a interview on 1/28/25 at 3:12 p.m. with Director of Nursing (DON), DON stated that all license staff are responsible for ensuring the proper administration of oxygen. DON stated it is important to ensure that residents' are receiving the correct amount of oxygen because the outcome could be respiratory distress, respiratory failure and it could be fatal for the residents. During a review of Resident 33's Order Summary Report, dated February 2022, the Order Summary Report indicated, Oxygen at 2L/min via nasal cannula continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33's Care Plan, dated 2/2022, the Care Plan interventions indicated, Oxygen as ordered: Oxygen at 2L/min via Nasal Cannula continuously. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, [undated], the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 3/2024, the P&P indicated, The comprehensive care plan includes the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 49145 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 19) was provided the prescribed liquid to drink during medication pass. This deficient practice resulted for Resident 19 unable to swallow his medications effectively and can potentially cause aspiration (accidentally inhaling food or liquid or medication through the vocal cords into the airway) to Resident 19. Findings: During a review of Resident 19's Admission Record , the Admission Record indicated Resident 19 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis including cerebral infarction (stroke) with right hemiplegia (paralysis that affects only side of the body) and dysphagia (difficulty swallowing). During a review of Resident 19's Minimum Data Set ([MDS] a resident assessment tool) dated 12/27/2024, the MDS indicated was unable to make decision for himself and required one to two person assist to complete his activities of daily living (ADLs] routine tasks/activities such as oral hygiene, eating, toileting hygiene and bathing. During a review of Resident 19's Order Summary, the Order Summary indicated on 12/ 17/2024, Resident 19 was prescribed by his primary physician a diet of Carbohydrate Controlled Diet (a diet prescribed to people to keep their blood sugar level stable) Dysphagia Puree texture (pudding-like texture that is smooth, blended or pureed) and nectar thick consistency (fluids thicker than fruit nectars, but not as thick as a thick shake). During a review of Resident 19's care plan on potential for nutrition risk dated 12/20/2019, the care plan indicated Resident 19 was on therapeutic mechanically altered diet and needed assistance with meals due to hemiplegia, cerebral infarction, , dysphagia (difficulty swallowing),), failure to thrive (a condition of marked decreased in appetite an difficulty in eating which could result to weight loss and malnutrition) and dementia (a condition when the person suffers loss of cognitive functioning such as thinking, remembering and reasoning that interferes with their daily life and activities). The goal of the care plan was for Resident 19 to tolerate current diet food texture without any complications with interventions including to encourage compliance with nectar thick liquid consistency, aspiration precaution, offer/ encourage fluids and to provide Resident 19 with prescribed diet of Carbohydrate Controlled Dysphagia Puree texture with Nectar thick liquids. During an observation on 1/28/2025 at 11:17 a.m., in Resident 19's room, Resident 19 was in bed in 45 degrees head of bed elevation and Registered Nurse Supervisor 1 (RNS 1) administered medications (crushed and mixed in apple sauce) to Resident 19 and RNS 1 did not provide Resident 19 with his prescribed liquid to drink. Resident 19 cleared his throat, coughed vigorously and observed whitish/yellowish secretions came out of his mouth. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2025 at 11:25 a.m., Registered Nurse Supervisor 1 (RNS 1) stated it was not a standard practice to offer residents who take their medications crushed and mixed with apple sauce, liquids to drink during medication pass. RNS 1 stated she did not have a liquid thickener (a food ingredient and/or thickening agent used to change the consistency of edibles and liquids, reducing the risk of coughing and choking) in the medication cart ready to be used during medication pass; however, it was important for the residents to be provided liquids prescribed to drink during medication pass to ensure the residents take their medications with no difficulty. During an interview on 1/28/2025 at 11:29 a.m., Registered Nurse Supervisor 2 (RNS 2) stated it was a standard professional practice of a licensed nurse to ensure the medication cart was prepared with prescribed liquids and thickener ready to be used during medication pass. RNS 2 stated the licensed nurse must make sure the residents will be able to take their medications with the prescribed liquids, as ordered by the physician. During an interview on 1/28/2025 at 12:29 p.m., the Director of Nursing Services (DON) stated the licensed nurses are expected to ensure the residents get their medications safely and appropriately by providing the prescribed liquid hydration to prevent aspiration. During a review of the facility's policy and procedure (P&P) titled, Encouraging and Restricting Fluids revised 10/2010, the P/P indicated the facility shall provide the residents with fluids necessary to maintain optimum health by ensuring the nursing staff follow the specific instructions concerning the residents' fluid intake. During a review of the facility's policy and procedure (P&P) titled Administering Medications undated, the P/P indicated the residents' medications are administered in a safe manner by the licensed nurses of the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed to maintain a medication error rate less than 5% (percent) during medication pass for one of four sampled residents (Resident 61) by failing to crush allopurinol ({medication used to treat gout} (type of inflammatory arthritis), Vitamin D) a nutrient that your body needs for building and maintaining healthy bones), and ferrous sulfate (an iron supplement used to treat iron deficiency) individually prior to administering. This failure resulted in a medication administration error rate of 12% exceeding the five (5) percent threshold. Findings: During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including encephalopathy (brain damage or disease that affects how the brain functions, dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool) dated 12/23/2024, the MDS indicated Resident 61 was severely cognitively (ability to think, understand, learn, and remember) impaired. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) with eating, hygiene, and dressing. During a review of Resident 61's Order Summary Report (a list of all currently active medical orders), dated 1/29/2025, the Order Summary Report indicated the following medication orders: 1. Allopurinol tablet 300 mg (milligrams- a unit of measurement for mass), 1 tablet by mouth one time a day for gout, order date 1/14/2025, start date 1/15/2025. 2. Cholecalciferol (a dietary supplement used to treat low level of Vitamin D) tablet 1000 unit (a unit of measurement for mass), give 2 tablets by mouth one time a day for supplement, order date 1/14/2025, start date 1/15/2025. 3. Ferrous Sulfate tablet 325mg, give one tablet by mouth one time a day for supplement, order date 9/25/24, start date 9/26/2024. 4. Fluticasone Propionate (a medication to treat allergies) Nasal Suspension 50mcg (a unit of measurement for mass), two sprays in each nostril one time a day for allergic rhinitis (inflammation of the inside of the nose). 5. Lacosamide ({medication to treat seizures}- a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) oral solution 10mg/ml, give 10ml by mouth every 12 hours for seizure disorder, order date 1/14/2025, start date 1/14/2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Lidocaine (medication used to relieve pain) external cream 5% (percent), apply to bilateral hips topically (used on the outside of the body) three times a day for arthritis, order date 12/27/2024, start date 12/27/2024. During an observation of medication administration on 1/29/2025 between 8:31 a.m. and 8:54 a.m., with Registered Nurse (RN) 1, RN 1 prepared, crushed all together, and administered the following list of medications to Resident 61 in applesauce: 1. Allopurinol tablet 300 mg (milligrams- a unit of measurement for mass), 1 tablet by mouth one time a day for gout, order date 1/14/2025, start date 1/15/2025. 2. Cholecalciferol (a dietary supplement used to treat low level of Vitamin D) tablet 1000 unit (a unit of measurement for mass), give 2 tablets by mouth one time a day for supplement, order date 1/14/2025, start date 1/15/2025. 3. Ferrous Sulfate tablet 325mg, give one tablet by mouth one time a day for supplement, order date 9/25/24, start date 9/26/2024. During an interview on 1/29/2025 at 10:15 a.m., with RN 2, RN 2 stated when administering medication that need to be crushed, the medications should be crushed and administered individually to prevent a potential drug interaction. During an interview on 1/29/2025 at 10:30 a.m., with RN 1, RN 1 stated she did not crush Resident 61's medications individually but should have done so. RN 1 stated there are some medications that should not be crushed and administered together so she should have not crushed them together and if the resident spits out the medication, RN 2 stated she would not know which medication the resident spit out. During an interview on 1/29/2025 at 11:38 a.m., with the Director of Nursing, the DON stated medications that require are to be crushed, should be crushed individually because of safety concerns, the resident may spit it out, and some medications should not be mixed. During a review of the facility's policy and procedure (P&P) titled, Crushing Medications, dated 4/2018, the P&P indicated, Crushing each medication separately and administering each with food is considered best practice.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45981 Based on observation, interview, and record review, the facility failed to remove an expired medication from medication cart in station 1 (Cart 1). This failure had the potential to result in the use of ineffective medication for the residents. Findings: During a concurrent observation and interview on 1/30/25 at 10:38 a.m. with Registered Nurse Supervisor (RNS 3) in Station 1, medication cart 1 had Famotidine Tablets (Heartburn Relief), 10 mg acid reducer expiration date of 07/24. RNS 3 stated that all license nurses are responsible for ensuring the medications inside the medication carts are not expired. RNS 3 stated medications that are expired could loose its strength and will not work effectively for the residents. During an interview on 1/30/25 at 10:40 a.m. with Registered Nurse Supervisor (RNS 2) in station 2, RNS 2 stated that all license nurses are responsible for ensuring that medications are not expired in the medication carts. RNS 2 stated medications that are expired could loose its strength and not work adequately for the residents, and the resident's condition will not improve. RNS 2 stated expired medications could be toxic for the residents and they could go into shock (life-threatening condition that occurs when the body is not getting enough blood flow) and cause death. During an interview on 1/30/25 at 2:22 p.m. with Director of Nursing (DON), DON stated all license staff are responsible for ensuring the medications in the cart are not expired. DON stated expired medications could cause the residents to have an allergic reaction that could result in death. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications dated 2020, the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. During a review of the facility's policy and procedure (P&P) titled, Administering Medications[undated], the P&P indicated Medications are administered in a safe and timely manner as prescribed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45981 Based an observation, interview and record review, the facility failed to ensure the dietary aide washed his hands upon entering the kitchen to deliver the food trays. This deficient practice had the potential to cause food-borne illnesses (an illness caused by eating or drinking contaminated food or water) to the residents residing in the facility. Findings: During an observation on 1/28/2025 at 12:40 p.m. in the kitchen, the Dietary Aide (DA 1) entered the kitchen and did not perform hand hygiene. Observed DA 1 was wearing mask below the nose. DA 1 proceeded to the food cart to deliver the food trays to the residents in the facility. During an interview on 1/28/2025 at 12:42 p.m. with DA 1, DA 1 stated that he should wash his hands upon entering the kitchen. DA 1 stated that he should have washed his hands to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another), which could cause the residents and staff to get sick. DA 1 stated that he did not wash his hand when he entered the kitchen and was not wearing his mask correctly. DA 1 stated it is important to keep his mask over his nose to prevent the spread of germs and potential contamination that could cause the residents to become sick. During an interview on 1/28/25 at 12:45 p.m. with Dietary Aide (DA 2), DA 2 stated hand washing is important to prevent cross contamination, which could cause the residents to become sick with diarrhea and vomiting. During an interview on 1/28/25 2:36 p.m. with District Manager (DM), DM stated hand washing should be done upon entering the kitchen, and between tasks to prevent cross contamination. DM stated cross contamination could cause food borne illness that would affect the residents in the facility and cause them to get sick. During a review of Dietary Aide Job Description, [undated], the Job Description indicated Practices safety, infection control, and emergency procedures according to facility/state/federal/HCSG polices. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 9/2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 9/2023, the P&P indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. During a review of the facility's P&P titled, Food: Preparation, dated 2/2023, the P&P indicated, All staff will practice proper hand washing techniques and glove use.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 43906 Based on interview and record review, the facility failed to ensure employee files were maintained and kept up to date for five out of five employees. 1. Ensure that upon hire and annually, employees had a Tuberculosis (TB- a lung disease) test, (a skin test to check if you have been infected with Tuberculosis). 2. Ensure health examinations were completed prior to hire and annually. These failures had the potential to negatively affect the patient's quality of care. Findings: During a record review of Certified Nursing Assist (CNA)7 employee file dated 11/14/2023 indicated CNA 7 did not have a health examination or TB screening prior to employment and then annually thereafter. During a record review of CNA 12's employee file dated 1/4/2024 indicated CNA12 did not have a health examination or TB screening prior to employment and then annually thereafter. During a record review of Licensed Vocational Nurse (LVN) 5's employee files dated 02/19/2024 indicated that LVN 5 did not have a health examination or TB screening prior to employment. During a record review of Licensed Vocational Nurse (LVN) 6's employee file dated 02/08/2024 indicated that LVN 5 did not have a health examination or evidence of a negative chest x-ray for TB prior to employment. During a record review of Registered Nurse Supervisor (RNS) 1 employee file dated 4/18/2024 indicated RNS1 did not have a health examination or TB screening prior to employment During a concurrent interview on 1/30/25 at 7:25 a.m. and record review of the employee files with the Director of Staff Development (DSD) .DSD stated he thought the health files were handled by the Infection Preventionist (IP). DSD stated that Registered Nurse Supervisor (RNS)1, Licensed Vocational Nurse (LVN) 5 and 6 and Certified Nursing Assistant (CNA) 7 and 12 did not have a health examination or TB test done upon hire or annually. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 1/31/25 at 12:45 p.m. with the Administrator (ADM) and record review employee health files. Adm stated the DSD is responsible for ensuring the health files are up to date for the employee's. ADM stated she was aware that the DSD was not aware he was responsible for the health examinations and TB screening for the staff and that he thought the IP was responsible. ADM stated TB test and health examinations are done upon hire and then annually for all staff members, ADM stated TB test are important because we do not want to have an outbreak of TB in the facility and health examinations are very important, we need to ensure that the staff are physically capable of caring of the residents.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43906 Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to ensure effective oversight of the facility and implementation of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey. This deficient practice resulted the facility to have repeat deficiencies in resident's rights, comprehensive resident centered care plans, pharmacy services, Quality assurance and performance improvements and infection control. Findings: During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies in resident's rights, comprehensive resident centered care plans, pharmacy services, Quality assurance and performance improvements and infection control. During a concurrent interview and record review on 1/31/2025 at 3:25 p.m. with the Administrator (ADM) the Quality Assurance Performance Improvement (QAPI), The ADM stated she could improve on the facility's QAPI program and that she has not been as diligent as she should have been. The ADM stated the QAPI program is essential for ensuring the concerns of the facility are addressed in a systematic process to achieve positive outcomes. During a review of the facility's policy and procedure (P&P), titled Quality Assurance and Performance Improvement (QAPI) Program, dated, 2/2020, the P&P indicated, The facility implements and maintains an ongoing, facility wide data driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for the resident's. The objectives of the QAPI program are to, provide a means to measure current and potential indicators for outcomes of care and quality of life. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Reinforce and build upon effective systems and process related to the delivery of quality care and services. Establish systems through which to monitor and evaluate corrective actions.The administrator is responsible for assuring that the facilities QAPI program complies with federal, state and local regulatory agency requirements. The QAPI committee reports directly to the administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation, interview, and record review, the facility failed maintain and observe infection control practices for three of three sampled residents (Resident 17, 45, and 61). This failure had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for the spread of infection. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility 10/8/2015 with diagnoses including cerebral infarction (loss of blood flow to a part of the brain) and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's Minimum Data Set ({MDS}- a resident screening tool) dated 12/20/2024, the MDS indicated Resident 17 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment. The MDS indicated Resident 17 was dependent (helper does all the effort) with toileting, lower body dressing, and showering. During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs and arms, usually do to a spinal cord injury) and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 45's MDS, the MDS indicated Resident 45 had no cognitive impairment. The MDS indicated Resident 45 was dependent (helper does all the effort) with eating, hygiene, showering, and dressing. During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a change in how your brain functions) and dysphagia (difficulty swallowing). During a review of Resident 61's MDS, the MDS indicated Resident 61 had severe cognitive impairment. The MDS indicated Resident 61 required partial/moderate assistance (helper does less than half the effort) with eating, hygiene, and dressing. During an observation of medication administration on 1/29/2025 at 8:31 a.m., Registered Nurse Supervisor (RNS) 1 was observed not sanitizing the blood pressure cuff or the medication basket prior to using for Resident 17. During an observation of medication administration on 1/29/2025 at 8:44 a.m., Registered Nurse Supervisor (RNS) 1 was observed not sanitizing the medication basket prior to using for Resident 45. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration on 1/29/2025 at 8:54 a.m., Registered Nurse Supervisor (RNS) 1 was observed not sanitizing the medication basket prior to using for Resident 61. During an interview on 1/29/2024 at 10:15 a.m., with Registered Nurse (RN) 2, RN 2 stated blood pressure cuffs and the white medication baskets should be sanitized between residents for infection control. RN 2 stated not sanitizing the equipment can result in cross contamination. During an interview on 1/29/2024 at 10:30 a.m., with RN 1, RN 1 stated she did not sanitize the blood pressure cuff or the white medication basket between residents to prevent cross contamination which could result in the resident potentially getting sick, hospitalized or dying from infection. During an interview on 1/29/2025 at 11:38 a.m., with the Director of Nursing (DON), the DON stated the staff are supposed to disinfect equipment between residents to prevent the spread of germs and cross contamination. During a review of the facility's Registered Nurse (RN) Job Description, dated 5/2022, the RN Job Description indicated, Adhere to the facility infection prevention and control practices. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner. Staff follows established facility infection control procedures for the administration of medications.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview, and record review, the facility failed to ensure 22 out of 36 resident rooms met the 80 square feet (sq. ft.- unit of area equal to a square foot long on each side) per resident in multiple resident rooms. Rooms one through 11 and rooms 14, 16 and rooms 18-26 house two residents per room. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (depressed mood causing significant impairment in daily life), post-traumatic stress disorder (unwanted memories of a trauma). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognition (ability to think, understand, learn, and remember) is intact. During a review of Resident 5's History & Physical (H&P) dated 4/5/2024 indicated Resident 5 has the capacity to understand and make decisions. During an observation on 1/28/2025 at 10:00 a.m., the following rooms were observed, rooms one through 11, 14, 16, and rooms 18-26 did not meet the requirement of 80 square feet per resident. During an interview on 1/30/2025 at 2:53 p.m.with Resident 5, Resident 5 stated the room is very small and the staff have to reach over my stuff to get gloves . During a review of the Client Accommodations Analysis Form (CAAF), provided by the Administrator (ADM) on 1/27/25, the CAAF indicated rooms one through 11 and rooms 14, 18 and rooms 18-26 were occupied with two residents per room and had a total square foot measurement of 143 sq. ft. During an interview on 1/29/2025 at 9:00 a.m., with the Administrator (ADM), the ADM stated she did not know she had to reapply for the room wavier every year. ADM stated she has never been told she cannot use the rooms without the approved room waiver.

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	01/31/2025

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49145 Based on interview and record review the facility failed to maintain a training program based off the facility assessment when five employee education files were reviewed and four out of the five employee education files were missing training on abuse, dementia, infection control, lesbian, gay, bisexual, transgender, queer (LGBTQ), behavioral health, resident rights, and communication. This failure has the potential to put the resident's safety at risk. Findings: During a review of Certified Nursing Assist (CNA)7 employee file dated 11/14/2023 indicated CNA 7 did not have abuse, dementia, LGBTQ behavioral health, resident's rights, infection control, communication training upon hire and no dementia, LGBT. behavioral health, resident's rights found annually. During a review of CNA 12's employee file dated 1/4/2024 indicated CNA12 did not have dementia, LGBTQ behavioral health, resident's rights, infection control, communication training upon hire and only three hours of dementia training found annually. During a review of Licensed Vocational Nurse (LVN) 6's employee files dated 02/8/2024 indicated that LVN 5 did not have abuse, dementia, LGBTQ behavioral health, resident's rights, infection control, communication training upon hire and no dementia, LGBTQ. behavioral health, resident's rights found annually. During a review of Registered Nurse Supervisor (RNS) 1 employee file dated 4/18/2024 indicated RNS1 did not have abuse, dementia, LGBTQ behavioral health, resident's rights, infection control, communication training upon hire. During a concurrent interview and record review on 1/30/25 at 07:25 a.m. with the Director of Staff Development (DSD) employee education for staff was reviewed DSD stated he received 1 day of training upon hire from a consultant and after that he never saw the consultant again. DSD stated he got a brand-new consultant last week. DSD states he did not know he needed a calendar with the annual trainings for staff to see. DSD stated that the CNA's require 12 hours of education annually include- 5 hours of dementia, 2 hours of abuse, fire hazard DSD states he cannot provide any proof that the required trainings are being done. DSD state the staff don't show up. DSD stated he does not follow up with the staff and he did not let the Administrator know the staff were not showing up for his in-services. DSD stated it is important for staff to be educated properly to ensure Resident safety. During a concurrent interview and record review on 1/31/25 at 12:45 p.m. with the Administrator (ADM) employee's RNS1, LVN 6 , CNA 7 and CNA 12's education files were reviewed. Adm stated the DSD is responsible for ensuring education is being provided to the staff upon hire and annually. Adm stated she assumed the DSD knew what he was supposed to do. ADM stated the DSD was not providing the required education requirements for the facility. ADM stated staff need to be educated upon hire and throughout the year to ensure our residents are cared for properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the DSD job description dated 10/2020, the DSD job description indicated the primary purpose of this position is to plan, organize, develop and direct all in-service education programs throughout the facility in accordance with the applicable federal, state and local standards, guidelines and regulations and as directed by the administrator to assure that the highest degree of quality residents care can be maintained at all times. During a review of the Facility's Assessment (a comprehensive evaluation of the residents and resources needed to care for them) dated 7/25/24 last updated 1/10/2025, the facility assessment indicated that staff members are provided with training upon hire and as needed on the following topics communication, resident's rights, abuse, infection control, dementia, behavioral health to ensure staff have the training needed to effectively perform their duties. During a review of the facility's policy and procedure (P&P) titled Competency of Nursing staff dated 05/2019 indicated, all nursing staff must meet the specific competency requirements of their respective Licensure and certification requirements defined by State law. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will participate in a facility-specific, competency-based staff development and training program; and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. Training and competency evaluations include elements of critical thinking and processes necessary to identify and report resident changes of condition. The type and amount of this training is based on the facility assessment and is specific to the different skill levels and licensure of staff.