| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055559 | A. Building<br>B. Wing | 03/13/2026 |

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

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident was free from significant medication errors for one of six sampled residents (Resident 2) by failing to:1.Administer Quetiapine Fumarate (Seroquel), an antipsychotic medication prescribed to treat mental health conditions) , as ordered by the physician from 3/5/2026 through 3/12/2026.2.Notify the physician when the Seroquel order contained no dosage on 2/24/2026 and when the medication was not administered for eight consecutive days.These failures had the potential to result in increased agitation and behavioral disturbances due to the omission (failure to administer an ordered dose of medication) of a prescribed medication.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses including Alzheimer's disease( a disease characterized by a progressive decline in mental abilities), gastrostomy ( a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia( difficulty in swallowing), unspecified dementia( a progressive state of decline in mental abilities), and depression (serious mental health condition characterized by persistent sadness and a loss of interest in activities that affects daily functioning),During a review of facility's pharmacy delivery receipt dated 2/4/2026 timed at 12:29 a.m., the pharmacy delivery receipt indicated Resident 2's Quetiapine Fumarate 25 milligrams (mgs- unit of measurement) with a quantity of 30 tablets were received by the facility.During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool) dated 2/6/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was dependent on the staff with oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to a chair.During a review of Resident 2's Order Summary Report dated 2/24/2026, the Order Summary Report indicated a physician telephone order of Quetiapine Fumarate (Seroquel) one tablet via gastrostomy tube tube (GT- a feeding tube inserted directly into the stomach through the abdomen used for long term nutrition, and administration of medication) at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by pulling out of GT. The Order Summary Report indicated no dose was ordered and documented for Seroquel.During a review of Resident 2's Medication Administration Record dated March 2026, the MAR indicated Quetiapine Fumarate one tablet via GT at bedtime for psychosis manifested by pulling out of GT. The MAR indicated Resident 2 did not receive Quetiapine Fumarate on 3/5/2026, 3/6/2026, 3/7/2026, 3/8/2026,3/9/2026, 3/10/2026, 3/11/2026, and 3/12/2026.During a review of Resident 2's electronic medication administration (EMAR) Progress Notes dated 3/5/2026 to 3/12/2026, the EMAR Progress Notes indicated the following:1.On 3/5/2026, the EMAR Progress Notes indicated that Quetiapine Fumarate give one tablet via GTube is on order and waiting for pharmacy.2.On 3/6/2026, the EMAR Progress Notes indicated that Quetiapine Fumarate was on order and pending pharmacy delivery.3.On 3/7/2026, the EMAR Progress Notes indicated Quetiapine Fumarate was on order and awaiting pharmacy delivery.4.On 3/8/2026, the EMAR Progress Notes Quetiapine Fumarate was on order.5.On<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3/9/2026, the EMAR Progress Notes indicated Quetiapine Fumarate was on order.6.On 3/10/2026, the EMAR Progress Notes indicated Quetiapine Fumarate was still on order.7.On 3/11/2026, the EMAR Progress Notes indicated Quetiapine Fumarate on order and calling pharmacy tonight.8.On 3/12/2026, the EMAR Progress Notes indicated Quetiapine Fumarate was on order and awaiting pharmacy delivery.During a concurrent observation and interview on 3/13/2026 at 10:55 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there was no Seroquel available for Resident 2 in the medication cart. LVN 1 stated the licensed nurses should have clarified the Seroquel order with the physician and contacted the pharmacy to follow up. LVN 1 stated he had never seen a pharmacy deliver medication without a physicianˆordered dose.During a concurrent interview and record review on 3/13/2026 at 11:02 a.m., with Registered Nurse Supervisor (RNS) 1 , reviewed Resident 2's Medication Administration Record for March 2026 and the Order Summary Report. RNS 1 stated Resident 2 had an order for Seroquel, one tablet at bedtime, for psychosis manifested by pulling out the gastrostomy tube (GT). RNS 1 stated a physician's order must include a medication dosage, and it was the responsibility of the licensed nurses to clarify and notify the physician regarding the missing Seroquel dose when the order was entered on 2/24/2026. RNS 1 stated she entered the telephone order for Quetiapine Fumarate on 2/24/2026 and did not include the dosage. RNS 1 stated the licensed nurses should have clarified the Seroquel order with the physician, entered the correct dose, and sent the complete order to the pharmacy. RNS 1 stated Resident 2's targeted behavior for Seroquel therapy was not being treated, and the behavior could worsen if the resident missed eight days of Seroquel. RNS 1 stated the licensed nurses should have notified the physician and initiated a changeˆinˆcondition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) report, as the omission of Seroquel represented a clinically important deviation from the resident's behavioral and cognitive baseline.During an interview on 3/13/2026 at 2:53 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have addressed the issue by contacting the physician and obtaining an order to resolve the problem. The DON stated she did not believe staff had contacted the pharmacy to determine why Seroquel had not been delivered to the facility. The DON stated the facility should have followed up by calling the pharmacy, notifying the physician and the responsible party, and completing a COC. The DON stated Resident 2 may experience increased agitation as a result of not receiving Seroquel for eight days.During a review of facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures, dated 2/2016, the P&P indicated to administer medications in a safe and effective manner.During a review of facility's P&P titled, The Physician Orders, dated 3/22/2022, the P&P indicated the facility will ensure all physician orders are complete and accurate. The P&P indicated medication orders will include name of medication, dosage, frequency, duration of order, route and the condition for which the medication is ordered. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview and record review, the facility failed to store food items safely for all residents by not ensuring that a carton of thickened water, chocolate pudding powder, frozen donut holes, and frozen pork chops were labeled with open dates.This failure had the potential to expose residents to foodˆborne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites).Findings:During an observation on 3/10/2026 at 8:20 a.m. in the kitchen, multiple open food items were found without open dates, including a carton of thickened water, chocolate pudding powder, frozen donut holes, and frozen pork chops.During an interview on 3/13/2026 at 11:48 a.m. with the Dietary Aide (DA), the DA stated all food items must be labeled with an open date once opened to ensure they were served fresh. The DA stated residents could get sick if food was not served fresh.During an interview on 3/13/2026 at 11:56 a.m. with the Dietary Supervisor (DS), the DS stated he was aware multiple open food items did not have open dates and acknowledged they should be labeled to ensure freshness and resident satisfaction. The DS added that there was a possibility of stomach issues when food was not fresh.During an interview on 3/13/2026 at 1:47 p.m. with the Administrator (ADM), the ADM stated when food was opened it must be dated to ensure freshness and food should be visually appealing. The ADM added there was a risk for residents to develop an upset stomach if food was not served fresh.During a review of the facility's policy and procedure (P&P) titled Food Storage dated 2/2023, the P&P indicated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain respect and dignity for one of two sampled residents (Resident 2) by standing over the resident while providing assistance during a meal.This failure had the potential to place Resident 2 at risk for choking and to negatively impact the resident's self^esteem.Findings:During a dining observation on 3/10/2026 at 12:29 p.m., Certified Nursing Assistant (CNA) 2 was observed standing while feeding Resident 2, who was seated in a Geri chair (a specialized padded recliner on wheels designed for individuals with limited mobility).<br>Resident 2's meal tray ticket indicated a regular diet with pureed texture (standard foods blended, mashed, or strained to a completely smooth, pudding^like consistency).During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses including Alzheimer's disease( a disease characterized by a progressive decline in mental abilities), gastrostomy( a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia( difficulty in swallowing), unspecified dementia( a progressive state of decline in mental abilities), and depression (serious mental health condition characterized by persistent sadness and a loss of interest in activities that affects daily functioning),During a review of Resident 2's Minimum Data Set (MDS-resident assessment tool) dated 2/6/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was dependent on the staff with oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to a chair.During a review of Resident 2's Order Summary Report dated 6/20/2025, the Order Summary Report indicated an order for enteral feed (tube feeding -a method of delivering nutrients directly into the stomach using a soft tube) order of Jevity 1.2 calorie ( CAL-high-protein, fiber fortified liquid nutrition formula) to administer via pump at 45 milliliters per hour for 12 hours. The Order Summary indicated the enteral feed will be on at 8:00 p.m. and off at 8:00 a.m.During a review of Resident 2's Order Summary Report dated 2/3/2026, the Order Summary Report indicated an order of Regular diet with pureed texture.During a telephone interview on 3/12/2026 at 5:13 p.m., CNA 2 stated she had been standing while assisting Resident 2 with a spoon during lunchtime. CNA 2 stated she was expected to sit while assisting the resident so the resident would not feel intimidated and for safety reasons. CNA 2 stated Resident 2's family member did not want the resident to eat with her hands, which is why staff the staff has to help her with the spoon during mealtime.During an interview on 3/13/2026 at 2:53 p.m., the Director of Nursing (DON), the DON stated staff should sit and be engaged with Resident 2 during meals. The DON stated Resident 2's dignity and safety could be affected when staff stand over her. The DON explained that sitting while assisting Resident 2 supports her dignity and helps prevent choking because staff can better observe whether the resident was chewing and swallowing her food.During a review of facility's policy and procedure (P&P) titled, Dignity, undated, the P&P indicated Each resident should be cared in a manner that will promote and enhance individuality, sense of well-being, and feelings of self-worth and self-esteem. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of four sampled residents (Resident 25) received a morning shower as requested and preferred by the resident. This failure resulted in Resident 25 waiting approximately six hours for a shower and had the potential to cause Resident 25 to experience feelings of uncleanliness.Findings:During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses of osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), quadriplegia(paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 25's care plan titled Resident 25 requires assistance and is dependent for Activities of Daily Living (ADLs) such as bathing, grooming, and personal hygiene, revised 9/19/2023, the care plan indicated a goal for Resident 25 was for ADL care and needs to be anticipated and met throughout the review period.During a review of Resident 25's History and Physical (H&P), dated 3/3/2026, the H&P indicated Resident 25 was alert and oriented to name, place and time and had normal speech. The H&P indicated Resident 25 was dependent on nursing staff and required total care with bathing.During a review of Resident 25 Minimum Data Set (MDS-a resident assessment tool) dated 2/26/2026, the MDS indicated Resident 25 had the ability to express ideas and wants. The MDS indicated Resident 25 had the ability to understand others. The MDS indicated Resident 25 needed partial to moderate assistance with showering and toileting. The MDS indicated Resident 25 needed substantial to maximal with oral hygiene, personal hygiene, dressing and transferring.During a review of the Facility's Care Center Assignment Sheet, dated 3/12/2026 the Facility's Care Center Assignment Sheet indicated Resident 25 was assigned to shower on Wednesdays and Saturdays in the morning on the day shift.During an interview on 3/24/2026 at 10:47 a.m. with Resident 25, the resident stated she had been waiting all morning to shower. Resident 25 stated she prefers to shower in the morning as early as possible. The resident stated Certified Nursing Assistant (CNA) 5 informed her at 10:45 a.m. that she could shower.During an interview on 3/13/2026 at 11:53 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 25's scheduled shower days were Wednesdays on the morning shift. CNA 5 stated Resident 25 preferred to shower in the morning. CNA 5 stated she showered Resident 25 at 1:30 p.m. and that she did not follow Resident 25's preferred shower time. CNA 5 stated she was assisting another resident, then took a break, and when she returned, lunch trays had already been delivered. CNA 5 stated she should have asked another nurse for assistance in showering Resident 25 before taking her break. CNA 5 stated if a resident prefers a morning shower, staff were expected to prioritize providing it. CNA 5 stated failing to honor a resident's preferred shower time could lead the resident to feel unheard, angry, depressed, or unclean when required to wait until the afternoon.During an interview on 3/13/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated residents have the right to choose their shower preferences and to have those preferences honored.During a review of the facility's policy and procedure titled, Dignity Resident Rights, undated, the P&P indicated, .Resident goals, choices, preferences, values, and beliefs are respected and honored to the extent possible. This begins with the initial admission and continues throughout the resident's facility stay. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of 18 sampled residents (Resident 2) was free from the use of a physical restraint (any object or device that an individual cannot remove easily which restricts freedom or movement). The facility failed to:1. Ensure an informed consent was obtained and documented before applying an abdominal binder (wide, elastic belt worn around the stomach reducing movement) as a restraint to prevent Resident 2 from pulling out her gastrostomy tube (GT- a feeding tube inserted directly into the stomach through the abdomen used for long term nutrition, and administration of medication) on 5/28/2025.2. Ensure an ongoing assessment, monitoring and evaluation to ensure the resident's safety and continued need for the use of the abdominal binder.This failure had the potential to place Resident 2 at risk for unnecessary prolonged use of physical restraint leading to impaired blood circulation, skin injuries and unnecessary use of Seroquel (antipsychotic, a type of medication prescribed to treat mental health problem) to prevent Resident 2 from pulling GT.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses including Alzheimer's disease( a disease characterized by a progressive decline in mental abilities), gastrostomy ( a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia( difficulty in swallowing), unspecified dementia( a progressive state of decline in mental abilities), and depression (serious mental health condition characterized by persistent sadness and a loss of interest in activities that affects daily functioning),During a review of Resident 2's Physician Order dated 5/28/2025, the Physician Order indicated application of abdominal binder for gastrostomy tube displacement prevention every shift.During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool) dated 2/6/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was dependent on the staff with oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to a chair.During a review of Resident 2's Order Summary Report dated 2/24/2026, the Order Summary Report indicated a physician order of Quetiapine Fumarate (Seroquel) one tablet via GT at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by pulling out of GT.During a review of Resident 2's Device Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered on application of a medical device), the Device Informed Consent indicated an abdominal binder will be placed at all times to prevent GT being pulled out. The Device Informed Consent indicated the consent was obtained from Family Member (FM) on 2/17/2026.During a review of Resident 2's Care Plan titled, Resident is at risk for complications of restraint use (abdominal binder), initiated and revised on 10/22/2025, the Care Plan indicated interventions including providing informed consent to resident or health care decision maker and assessing for adverse effects (a harmful or unwanted result caused by a treatment, medicine or external factor) of restraint use such as skin breakdown, decrease functional ability and confusion.During a telephone interview on 3/12/2026 at 5:13 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2 used an abdominal binder to prevent her from tugging or pulling on the GT. CNA 2 stated she checked the abdominal binder during incontinence care to ensure it was not too tight and that the GT remained in place. CNA 2 stated if the abdominal binder was not properly monitored, Resident 2 could develop redness, irritation, or a pressure injury from the abdominal binder.During a concurrent interview and record review on 3/12/2026 at 4:36 p.m., and during a subsequent interview on 3/13/2026 at 11:02 a.m., with Registered Nurse Supervisor (RNS) 1,<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 2's electronic chart was reviewed. RNS 1 stated the abdominal binder order for Resident 2 was initiated on 5/28/2025, but informed consent for the abdominal binder was not obtained until 2/17/2026. RNS 1 stated consent had not been obtained at the time the binder was first applied and stated this was missed by the facility. RNS 1 stated the facility should have obtained informed consent from the resident or the family representative before applying the abdominal binder.RNS 1 stated that Certified Nursing Assistants (CNAs) apply the binder and licensed nurses were responsible for ensuring correct placement because improper placement can restrict the resident's abdominal area and cause nausea, discomfort, or pain. RNS 1 stated Resident 2 received Seroquel 25 mg via gastrostomy tube at bedtime for psychosis manifested by pulling at the GT, and the abdominal binder was used to prevent her from pulling out the tube. RNS 1 stated the abdominal binder was removed only during personal care and adult brief changes. RNS 1 stated there was no monitoring system in place for the use of the abdominal binder. RNS 1 stated the facility should have performed ongoing assessment and monitoring to identify potential complications such as skin breakdown or impaired circulation.During an interview on 3/13/2026 at 2:53 p.m., with the Director of Nursing (DON), the DON stated the facility's expectation was to obtain informed consent before applying an abdominal binder for Resident 2. The DON stated that failing to conduct assessment and monitoring of the abdominal binder could result in skin breakdown and bruising, and staff would not be able to determine whether the resident continued to require the binder to prevent pulling on the gastrostomy tube (GT).During a review of facility's policy and procedure (P&P) titled, Use of Restraints, undated, the P&P indicated restraint will only be used after obtaining a consent from the resident and/or representative. The P&P indicated restrained individuals will be reviewed regularly to determine whether they are a candidate for restraint reduction and on-going reevaluation for the need for restraints will be documented by the facility. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe discharge and transfer for two of two sampled residents (Resident 7 and Resident 11) by falling to:1. Ensure the Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) was notified when Resident 7 was transferred to the General Acute Care Hospital (GACH).2. Ensure Resident 7 and Resident 11 were offered a bed hold before being transferred to the GACH.These failures placed Resident 7 and Resident 11 at risk for an unsafe transfer and violated Resident 7 and Resident 11's rights to informed transfer to GACH. Findings:During a review of Resident 7's admission Record, the admission record indicated Resident 7 was admitted on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 7 with diagnosis including schizophrenia (a serious mental disorder in which people interpret reality abnormally), anxiety (emotion characterized by feelings of tension, worried thoughts) and dementia (loss of memory, language, problem-solving and other thinking abilities).During a review of Resident 7's History & Physical (H&P) dated 6/25/2025, the H&P indicated Resident 7 did not have the ability to understand and make decisions.During a review of Resident 7's Minimum Data Set (MDS-resident assessment tool) dated 2/13/2026, the MDS indicated Resident 7's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 7 needed partial/moderate assistance (helper does less than half the work) with activities of daily living (ADL's) like toileting, bathing and dressing).During a review of Resident 7's Transfer Form dated 10/15/2025, the transfer form indicated Resident 7 was transferred to the GACH on 10/15/2025.During a review of Resident 7's Transfer Form dated 11/11/2025, the transfer form indicated Resident 7 was transferred to the GACH on 11/11/2025.During a review of Resident 11's admission Record, the admission record indicated Resident 11 was admitted to the facility on [DATE], with diagnosis including anemia (a condition in which there is lack of enough red blood cells), bone cancer (uncontrolled growth of cells) and hypertension (high blood pressure).During a review of Resident 11's History & Physical (H&P) dated 12/17/2025, the H&P indicated Resident 11 does not have the capacity to understand and make decisions.During a review of Resident 11's Minimum Data Set (MDS a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 11 had severe cognitive impairment. The MDS indicated Resident 11 was dependent (helper does all the work) with activities of daily living (ADL's) like toileting, bathing and dressing).During a review of Resident 11's Transfer Form dated 12/11/2025, the transfer form indicated Resident 11 was transferred to the GACH on 12/11/2025.During a concurrent interview and record review on 3/12/2026 at 3:09 p.m. with the Registered Nurse Supervisor (RNS), Resident 7's transfer forms dated 10/15/2025 and 11/11/2025, and Resident 11's transfer form dated 12/11/2025, were reviewed. The RNS stated the Ombudsman was not notified when Resident 7 was transferred to the GACH on 10/15/2025 and should have been. The RNS also stated Resident 7 was not provided information on the duration state bed hold on 10/15/2025 or 11/11/2025, and Resident 11 was not provided information on the duration state bed hold on 12/11/2025, and they should have been. The RNS stated when residents are transferred to the GACH, the Ombudsman should be notified to ensure the discharge and placement meet the residents' needs. The RNS stated a bed hold must be offered upon discharge so residents do not worry and know they will have a bed when they return to the facility.During an interview on 3/13/2026 at 3:16 p.m. with the Director of Nursing (DON), the DON stated the Ombudsman serves as an advocate for residents and should be notified when a resident was discharged to the GACH to ensure the resident was placed at the appropriate level of care. The DON stated when a resident was discharged to the GACH, resident should be provided information on the duration state bed hold so the resident does not worry and knows a bed will be available upon their return.During a review of the facility's policy and procedure (P&P) titled Bed Holds and Returns, (continued on next page) |

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| | 055559 | A. Building<br>B. Wing | 03/13/2026 |

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

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 10/2022, the P&P indicated Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents/representatives are provided written information regarding the facility and state bed hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: notice 1: well in advance of any transfer ( e.g., in the admission packet); and notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).During a review of the facility's P&P titled Residents Rights (undated) the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an alternative means of communication in a language that the resident could understand for one of three sampled residents (Resident 2).This failure had the potential to cause Resident 2 to feel frustrated and isolated, and to limit her ability to communicate her needs to staff, which could lead to delays in receiving appropriate care and services.Findings:During an observation on 3/10/2026 at 12:00 p.m., Resident 2 was seated in a Geri chair (a specialized padded recliner on wheels designed for individuals with limited mobility) in the lobby, smiling and speaking in a foreign language.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses including Alzheimer's disease( a disease characterized by a progressive decline in mental abilities), gastrostomy( a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia( difficulty in swallowing), unspecified dementia( a progressive state of decline in mental abilities), and depression (serious mental health condition characterized by persistent sadness and a loss of interest in activities that affects daily functioning),During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool) dated 2/6/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was dependent on the staff with oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to a chair.During a review of Resident 2's Care Plan titled, The resident has impaired communication as evidenced by rarely being able to make herself understood or understand others related to cognitive impairment, dementia, Alzheimer's disease, impaired hearing in the left ear, and use of another language, initiated on 3/13/2023, the Care Plan indicated a goal of meeting Resident 2's daily communication needs. The Care Plan interventions included providing emotional support and encouragement.During an interview on 3/10/2026 at 12:20 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 was unable to speak English and communicated in another language. CNA 1 stated she used hand signals and body gestures to communicate with Resident 2 and sometimes relied on the resident's family member to help translate or interpret for Resident 2. CNA 1 stated there were no visual aids or communication boards (a visual tool with symbols or words that helps residents with limited verbal, cognitive, or hearing abilities express their needs) in Resident 2's room to assist with communication, and no staff at the facility spoke Resident 2's language.During an interview on 3/11/2026 at 4:05 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated staff monitored Resident 2's body language as a way to communicate with her. LVN 3 stated relying on body language alone was not an effective method of communication. LVN 3 stated Resident 2 could experience a decline in her activities of daily living (ADLs-such as bathing, dressing, and toileting) if staff were unable to address her concerns or needs due to a lack of proper communication.During an observation on 3/12/2026 at 12:28 p.m. in the lobby, Resident 2 was seated in a Geri chair and was yelling in a foreign language. Licensed Vocational Nurse (LVN) 2 approached, sat beside Resident 2, and used a translator app (a mobile application that can instantly translate text, speech, images, and real˜time conversations in multiple languages) on his personal phone to help interpret what Resident 2 was saying as she pointed to people and objects in the lobby.During a concurrent observation and interview on 3/12/2026 at 12:32 p.m., with LVN 2, LVN 2 stated there was no communication board in Resident 2's room. LVN 2 stated using a translation app on his personal phone was not an appropriate method for communicating with Resident 2 because it was unclear whether the resident understood what he was communicating to her.During an interview on 3/12/2026 at 4:21 p.m., with Registered Nurse Supervisor (RNS) 1 , RNS 1 stated using hand signals (continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to communicate with Resident 2, who does not speak English, was not an effective method of communication. RNS 1 stated staff may not accurately understand the resident's needs, which could result in her concerns not being addressed properly.During an interview on 3/12/2026 at 12:44 p.m. and subsequent interview on 3/13/2026 at 2:53 p.m. with the Director of Nursing (DON), the DON stated Resident 2 needs a communication board to help communicate with the staff and using a translator app on a personal phone was not a good way to communicate with Resident 2. The DON stated it was important to meet Resident 2 needs for communication to ensure her wants and needs were met.During a review of facility's policy and procedure (P&P) titled, Accommodation of Residents Communication, dated 2/19/2026, the P&P indicated The facility will provide adaptive devices as needed to enable the resident to communicate as effectively as possible. The P&P indicated the facility will help residents with communication challenges through several adaptive services. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 7), who was dependent on staff for Activities of Daily Living (ADLs), received appropriate personal care. The facility failed to:1.Ensure Resident 7's long fingernails were trimmed and free of dirt and black grime underneath.This failure placed Resident 7 at risk for discomfort and increased the risk of infection from crossˆcontamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary conditions) due to inadequate nail hygiene.Findings:During a review of Resident 7's admission Record, the admission record indicated Resident 7 was admitted on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 7 with diagnosis including schizophrenia (a serious mental disorder in which people interpret reality abnormally), anxiety (emotion characterized by feelings of tension, worried thoughts) and dementia (loss of memory, language, problem-solving and other thinking abilities).During a review of Resident 7's History & Physical (H&P) dated 6/25/2025, the H&P indicated Resident 7 did not have the ability to understand and make decisions.During a review of Resident 7's Minimum Data Set (MDS-resident assessment tool) dated 2/13/2026, the MDS indicated Resident 7's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 7 needed partial/moderate assistance (helper does less than half the work) with activities of daily living (ADL's) like toileting, bathing and dressing).During a concurrent observation and interview on 3/13/2026 at 8:36 a.m. in Resident 7's room, Resident 7 was observed eating breakfast. Resident 7's fingernails were long with visible dirt and black grime underneath. Resident 7 stated he would like to have his fingernails cleaned and trimmed.During a concurrent observation and interview on 3/13/2026 at 8:45 a.m. with Certified Nursing Assistant (CNA) 4 at Resident 7's bedside, CNA 4 stated Resident 7's fingernails were dirty and long and needed to be cleaned and trimmed. CNA 4 stated there was a possibility of bacteria accumulating under Resident 7's fingernails, which could make him sick, and added that Resident 7 could also scratch and hurt himself.During an interview on 3/13/2026 at 2:56 p.m. with the Director of Nursing (DON), the DON stated residents' fingernails need to be kept clean and trimmed to prevent the possibility of ingesting bacteria and developing stomach issues.During a review of the facility's policy and procedure (P&P) titled Nail Care dated 10/2022, the P&P indicated To provide residents safe, hygienic, and thorough nail care assistance. Direct care staff will consult with a Registered nurse for any special directions as they may apply to a diabetic residentPROCEDURE:1. Gather needed equipment2. Explain procedure and provide privacy to resident3. Wash hands4. Soak resident's hands or feet in warm soapy water for 2-3 minutes.5. Clean nails and under nails.6. Thoroughly dry hands/feet.7. File nails straight across, if needed, to a length to allow white to show under the entire nail, leaving no rough edges.8. Apply lotion to skin. (Do not apply lotion between toes)9. Wash hands10. Clean equipment, as needed11. Notify RN if any new nail, cuticle, or skin issues are observed.12. Document any nail care provided |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 41) received ongoing activities in accordance with their comprehensive assessment, preferences, and interests, and supported their physical, mental, and psychosocial well-being.This failure had the potential to result in decreased physical activity and diminished sense of self-worth for Resident 41.Findings:During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was admitted to the facility on [DATE] ith diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 41's History and Physical (H&P), dated 1/8/2025, the H&P indicated Resident 41 had the capacity to understand and make decisions.During a review of Resident 41's Minimum Data Set (MDS-a resident assessment tool), dated 1/9/2026, the MDS indicated Resident 41 needed substantial to maximal nursing assistance with transferring, toileting, showering and dressing.During a review of Resident 41 Care Plan, dated 1/16/2025, the Care Plan indicated Resident 41 liked to exercise. The Care Plan indicated it is important for Resident 41 to engage in his favorite activities. and exercise.During a review of Resident 41's Recreation Comprehensive Assessment, dated 1/16/2025, the Recreation Comprehensive Assessment indicated the things Resident 41 likes to do currently and in the past was reading and exercise.During an interview on 3/11/2026 at 1:13 p.m., with Resident 41, Resident 41 stated he used to be active and likes to walk.During a concurrent interview and record review on 3/13/2026 at 10:00 a.m., with Activities Director (AD), Resident 41 Participation Record, dated January 2026, February 2026 and March 2026 was reviewed, the participation records indicated no documentation that Resident 41 was offered exercise, physical activity and walking. AD stated if the activities Resident 41 likes were not offered it could lead to depression.During an interview on 3/13/2026 at 3:29 p.m., with the Director of Nursing (DON), the DON stated the AD needs to be offering Resident 41 activities he likes and that motivate him to decrease depression and for good comradery (mutual trust, and friendship) with other residents.During a review of the facility's policy and procedure (P&P), titled Resident Self Determination and Participation the P&P indicated, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: daily routine, such as sleeping and waking, eating, exercise and bathing schedules; personal care needs, such as bathing methods, grooming styles and dress; health care scheduling, such as times of day for therapies and certain treatments; providers of healthcare services; activities, hobbies and interests;. Residents are provided assistance as needed to engage in their preferred activities on a routine basis. For example: if the resident enjoys reading, the facility will provide access to books (in large print if needed); if the resident enjoys regular exercise, he or she will be assisted attending exercise classes or given access to open areas for walks. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 67) received a recommended followˆup appointment with an ear, nose, and throat (ENT-specialist for diminished hearing) per recommendation of ENT physician on 4/16/2025.This failure caused Resident 67 emotional distress due to frequently needing staff to repeat themselves and placed the resident at risk for miscommunicating her needs.Findings:During a review of Resident 67's admission Record, the admission Record indicated Resident 67 was admitted to facility on 1/14/2025, and readmitted on [DATE], with diagnoses including hearing loss, hypertension (high blood pressure) and muscle weakness.During a review of Resident 67's History & Physical (H&P) dated 1/31/2025, the H&P indicated Resident 67 did not have the capacity to understand and make decisions.During a review of Resident 67's Minimum Data Set (MDS-resident assessment tool) dated 1/21/2026, the MDS indicated Resident 67's cognition (ability to think, understand, learn, and remember)was intact. The MDS indicated Resident 67 was dependent (helper does all the work) with activities of daily living (ADL's) like toileting, bathing and dressing).During an interview on 3/10/2026 at 12:28 p.m. with Resident 67, Resident 67 stated she needed staff to repeat themselves because she was hard of hearing. Resident 67 also stated that hearing aids would help her hear better.During an interview on 3/13/2026 at 10:14 a.m. with Certified Nursing Assistant (CNA 5), CNA 5 stated Resident 67 had difficulty hearing and could benefit from hearing aids. CNA 5 stated she would feel lost if she were unable to hear and believed there was a possibility that Resident 67's needs might not be met due to her hearing loss.During a concurrent interview and record review on 3/13/2026 at 1:15 p.m. with the Registered Nurse Supervisor (RNS), Resident 67's ENT Physician Progress Note dated 4/16/2025 was reviewed. The note indicated Resident 5 with diminished hearing and a recommendation for a followˆup appointment in six months. The RNS stated Resident 67 should have been seen by the ENT in October 2025. The RNS stated difficulty hearing could make it hard for Resident 67 to express her needs and increase the potential for miscommunication.During an interview on 3/13/2026 at 3:02 p.m. with the Director of Nursing (DON), the DON stated Resident 67 should have had a followˆup appointment with the ENT last year. The DON stated Resident 67 was at risk of having her needs unmet due to her hearing loss.During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living dated 3/2018, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Communication (speech, language, and any functional communication systems). Care and services to prevent and/or minimize functional decline. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 25) was provided with additional food after informing Restorative Nursing Assistant (RNA) 1 she was still hungry.This failure had the potential to result in inadequate caloric intake and possible weight loss for Resident 25 who requested and were not offered additional food items of their choice and preference.Findings:During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition ( a life threatening deficiency of protein and energy), nutritional anemia ( a common disorder caused by a lack of essential nutrients), and hypertension (HTN-high blood pressure).During a review of Resident 25 Minimum Data Set (MDS-a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 25 had the ability to express ideas and wants. The MDS indicated Resident 25 had the ability to understand others. The MDS indicated Resident 25 needed nursing supervision and touching assistance with eating. The MDS indicated Resident 25 needed substantial to maximal assistance with oral hygiene, personal hygiene, dressing and transferring.During a review of Resident 25's History and Physical (H&P), dated 3/3/2026, the H&P indicated Resident 25 was alert and oriented to name, place and time and had normal speech. The H&P indicated Resident 25 was dependent on nursing staff and required total care with bathing.During a review of Resident 25's Order Summary, dated 2/17/2026, the Order Summary indicated Resident 25 had an order for a regular no salt and regular textured diet.During an interview on 3/10/2026 at 12:52 p.m., with Resident 25, Resident 25 stated she wanted more chili on her potatoes and will request more chili from RNA 1.During an observation on 3/10/2026 at 1:06 PM in Resident 25's room, Resident 25 told RNA 1 she was still hungry and wanted more chili. RNA 1 was observed cutting up her baked potatoes in multiple tiny pieces then went to assist two other residents.During an interview on 3/10/2026 at 1:52 p.m., with RNA 1, RNA 1 stated Resident 25 told him she was still hungry. RNA 1 stated when a resident requests another tray or indicates they were still hungry, he should provide additional food for the resident.During an interview on 3/13/2026 at 3:24 p.m., the Director of Nursing (DON), the DON stated she had inˆserviced RNA 1 on offering residents additional food or appropriate alternatives to ensure they have enough to eat and to help prevent weight loss.During a review of the facility's policy and procedure (P&P) titled, Dignity Resident Rights, undated, the P&P indicated, .When assisting with care, residents are supported in exercising their rights. For example, residents are encouraged to.eat, and conduct activities of daily living as they choose . |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a coordinated hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) plan of care was integrated with the facility's plan of care and accessible to facility nursing staff for one of six residents reviewed for hospice services (Resident 5).The facility failed to:1. Incorporate Resident 5's active order for morphine (opioid pain medication) and fentanyl ( opioid pain medication) into the facility care plan,2.Document an effective communication process with the hospice provider to ensure 24ˆhour continuity of care, and maintained conflicting medication orders in Resident 5's health record without a coordinated plan between the hospice provider and the facility.This failure had the potential to put Resident 5 at risk for missed care, duplicate therapy, and adverse events, including respiratory depression and opioid overdoseFindings: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 right sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) , diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and bi polar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 5's History & Physical (H&P) dated 1/31/2026, the H&P indicated Resident 5 did not have the capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool) dated 1/7/2026, the MDS indicated Resident 5's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 5 was dependent (helper does all the work) with activities of daily living (ADL's like toileting, bathing and dressing). The MDS indicated Resident 5 was taking opioids (pain medication). The MDS indicated Resident 5 was receiving hospice services.During a review of Resident 5's hospice Patient Care Order dated 1/26/2026, the Patient Care Order indicated an order for:1.morphine 20 milligrams/milliliter (mg/ml -units of measure) oral (by mouth) administer one ml every 4 hours as needed (PRN) for severe pain.2.Fentanyl 25 microgram/ hour (mcg/hr unit of measure and time) transdermal (skin) patch, apply one patch transdermal every 72 hours for severe pain, discontinued (d/c) on 2/16/2026.During a review of Resident 5's Order Recap Report , the Order Recap Report indicated Resident 5 was receiving fentanyl 50 mcg/hr transdermal patch apply 1 patch transdermal every 72 hours for severe pain and apply a 25 mcg /hr transdermal patch. Apply one 50 mcg/hr and one 25 mcg /hr for a total dose of 75 mcg/hr. Hold for respirations less than (<) 12. Hospice nurses to apply patches, start date 2/16/2026, (d/c) on 3/9/2026.During a review of Resident 5's Order Recap Report, the Order Recap Report indicated Resident 5 was receiving fentanyl 50 mcg/hr transdermal patch, apply 2 patches transdermal every 72 hours for severe pain for a total dose of 100 mcg/hr, hold for respirations < 12. Hospice nurse to apply patches, start date 3/09/2026.During an interview on 3/12/2026 at 12:15 p.m. with the hospice Registered Nurse (HRN), the HRN stated Resident 5's fentanyl pain medication dose had been increased multiple times in the last month. HRN stated Resident 5's care plans were on the HRN's lap top with no access for facility nurses.During a concurrent interview and record review on 3/13/2026 at 1:02 p.m. with the Registered Nurse Supervisor (RNS), Resident 5's hospice interdisciplinary ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) care plans dated 1/27/2026 through 3/10/2026 and the facility's care plan titled Resident 5 at risk for opioid overdose were reviewed. RNS stated no coordinated plan of care was found for use of fentanyl or morphine. The RNS stated hospice and facility care plans must be integrated to ensure continuity and to avoid missed care. RNS stated she could not find any coordinated plan for Resident 5's use of fentanyl or morphineDuring an interview on 3/13/2026 at 3:11 p.m. with the Director of Nurses (DON), (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055559 | A. Building<br>B. Wing | 03/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bay Crest Care Center | 3750 Garnet Street<br>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.

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the DON stated no comprehensive plan of care was in place for Resident 5's fentanyl and morphine use. The DON stated hospice nurses and facility nurses should work together to ensure Resident 5's continuity of care, pain being managed, and to reduce negative outcomes.During a review of the facility's policy and procedure (P&P) titled Hospice Program (undated), the P&P indicated Hospice services are available to residents at the end of life coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. The coordinated care will be revised and updated as necessary to reflect the residents current status .<br> |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices for two of 18 sampled residents (Resident 2 and Resident 9). Specifically, the facility failed to:1.Provide hand hygiene (including handwashing with soap and water or use of alcohol^based hand sanitizers) for Resident 2 before lunch service, as resident used her bare hands to eat.2.Performed COVID 19 (highly contagious respiratory disease caused by Coronavirus, which is transmitted thru coughing, talking, sneezing and touching contaminated surfaces) testing for staff who cared for Resident 9 after the resident tested positive for COVID^19.These failures had the potential to contribute to the transmission and spread of infection among residents, staff, and visitors in the facility. Findings:<br><br>1.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2 with diagnoses including Alzheimer's disease( a disease characterized by a progressive decline in mental abilities), gastrostomy( a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia( difficulty in swallowing), unspecified dementia( a progressive state of decline in mental abilities), and depression (serious mental health condition characterized by persistent sadness and a loss of interest in activities that affects daily functioning),<br><br>During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool) dated 2/6/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to think, understand, learn, and remember). The MDS indicated Resident 2 was dependent on the staff with oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to a chair.<br><br>During an observation on 3/12/2026 at 12:37 p.m., Certified Nursing Assistant (CNA) 1 brought Resident 2's lunch tray. Resident 2, who was seated in a Geri chair (a specialized padded recliner on wheels designed for individuals with limited mobility), was observed eating her food with her bare hands and fingers. Hand hygiene was not offered or provided to Resident 2 before she began eating.<br><br>During an interview on 3/12/2026 at 12:46 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated it was important to offer and provide hand hygiene to Resident 2 to remove germs present on the resident's hands. CNA 1 stated that germs on Resident 2's hands could be transferred to her mouth and make her sick, leading to infection.<br><br>During an interview on 3/13/2026 at 10:53 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated CNA 1 should have provided hand sanitizer to Resident 2 before eating to help prevent illness caused by dirty hands and fingers.<br><br>During an interview on 3/13/2026 at 2:53 p.m., with the Director of Nursing (DON), the DON stated not providing hand hygiene to Resident 2 could affect her dignity and had the potential to cause infection.<br><br>2. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was admitted to facility on 9/11/2025 with diagnoses of depression (medical illness causing persistent sadness, hopelessness, and a loss of interest in activities), hypertension (HTN-high blood pressure), chronic kidney disease (a long term condition where the kidneys are damaged and cannot filter blood effectively as they should for a period of at least three months) and cerebral infarction (lack of (continued on next page) |

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| | 055559 | A. Building<br>B. Wing | 03/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bay Crest Care Center | 3750 Garnet Street<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | adequate blood supply to the brain).<br><br>During a review of Resident 9's History and Physical (H&P), dated 9/12/2025, the H&P indicated Resident 9 did not have the capacity to understand and make decisions but is able to make decisions for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).<br><br>During a review of Resident 9's Minimum Data Set, (MDS-a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 9 needs partial to moderate assistance with oral hygiene, toileting, showering, sitting, lying down. The MDS indicated Resident 9 was not up to date for the COVID 19 vaccination.<br><br>During a review of Resident 9's [NAME] of Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death), dated 3/3/2026, the COC indicated Resident 9 went to the General acute Care (GACH) for evaluation of septic (presence of harmful microorganisms in the blood) arthritis on the right knee.<br><br>During a concurrent interview and record review on 3/11/2026 at 1:34 p.m., with Infection Preventionist Nurse (IPN), the facility's policy and procedure (P&P) titled Covid-19 Management, dated 1/2025, was reviewed. The P&P indicated When contact tracing is feasible serially test close contacts and exposed staff identified in contact tracing three times on days one, three, and five after the last exposure. The IPN stated Resident 9 had swelling and pain in the right knee and was transferred to the GACH on 3/3/2026. The IPN stated Resident 9 tested positive for Covid-19 on 3/4/2026 in the GACH. The IPN stated Resident 9 returned to the facility on 3/5/2026. The IPN stated Resident 9 could have contracted Covid-19 here at facility from visitors or staff. The IPN stated contact isolation (measures used to prevent the spread of germs transmitted through direct patient contact or indirect contact with their environment), started on 3/6/2026. The IPN stated there was no Covid-19 testing done for staff exposed to Resident 9. The IPN stated she did not identify staff exposed to Covid-19 to prevent an outbreak because the staff did not have any symptoms.<br><br>During a review of facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 9/18/2023, the P&P indicated The facility considers hand hygiene as the primary means of preventing infection. The P&P indicated residents, family members and visitors are encouraged to practice hand hygiene.<br><br>During a review of facility's P&P titled, Assisting the Resident with In-Room Meals, the P&P indicated The resident is prepared to receive the meal by washing hands and face, bedpan and urinal was offered and hair was combed. |