DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055559	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY CREST CARE CENTER	3750 GARNET STREET , TORRANCE, California, 90503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of four complaints and two facility-reported incident (FRI). Complaint numbers: 2739062, 2740613, 2743695, 2784471. Facility-reported incident number: 2785524 and 2738650. This inspection was limited to the specific complaint and facility-reported incident investigated and does not represent the findings of a full inspection of the facility. No deficiencies were written for complaint numbers 2739062, 2740613, & 2743695 and facility reported incident number 2738650. Two deficiencies were written for complaint number 2784471 and FRI 2785524. See F656 and F657.	F0000	**The preparation and/or the execution of the plan of correction does not constitute admission of our agreement by the provider of true facts alleged or conclusions of our agreement by the provider of true facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of the federal and state law require.** **This plan of correction constitutes Bay Crest Care Center's credible allegation of compliance.**	3/2/26
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10,	F0656	**Corrective Action for Deficient Practice:** On 2/25/26, the Director of Nursing (DON) developed the care plan for Resident 1 on refusal of care and treatment and included goals and interventions. **Identification of Other Affected Residents:** On 2/24/26, the DON conducted staff interviews to identify residents who had exhibited episodes of refusal of care. 8 residents were identified as having instances of refusal of care. On 2/25/26, the DON developed/updated a care plan for the identified residents to address the refusal of care. **Systemic Changes:** On 3/2/26, the DON initiated an in-service to licensed nurses on the policy and procedure titled "Care Plan Comprehensive" with a focus that each resident's care plan is designed to incorporate identified problem areas and incorporate risk and contributing factors associated with identified problems. Interventions in the care plans are designed in relationships between the residents' problem areas and their causes.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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
Rita	Admin	3-18-26

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F0656 SS = D	Continued from page 1 including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to develop an individualized care plan with measurable objectives, timeframes, and interventions to meet the resident's needs for one of three sampled residents (Resident 1).The facility did not develop an individualized care plan addressing Resident 1's refusal of care and treatment, including goals and interventions. This deficient practice had the potential to negatively affect the delivery of necessary care and services. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on 9/28/2025 with diagnoses including dementia (a progressive state of decline in mental abilities) and atrial fibrillation (irregular heartbeat).	F0656	Monday through Friday, during the Clinical Meeting, the clinical team (Director of Nursing, Director of Staff Development, Infection Preventionist, Director of Rehab, Social Service Director) will review Change of Conditions as well as the progress notes from the day prior to identify any episodes of refusal of care. The clinical team will conduct an audit of the resident's care plans for refusal of care. Negative findings will be corrected immediately. **Monitor to Ensure Ongoing Compliance and Responsible Individuals:** DON and/or designee will report findings of the care plan audits monthly x 3 months to QAA committee for further evaluation and recommendations. **Compliance Date:** 3/2/26	3/2/26

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F0656 SS = D	Continued from page 2 During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/5/2026, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was severely impaired and required maximal assistance (helper does more than half the effort) with toileting, bathing, and showering. During a review of Resident 1's Nurses Progress Notes dated 11/15/2025, the Nurses Progress Notes indicated Resident 1 refusing to be showered. During a review of Resident 1's Interdisciplinary (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Care Conference Note dated 11/24/2025, the IDT Care Conference Note indicated Resident 1 refusing meals and medications. During a review of Resident 1's Follow-Up Note dated 12/26/2025, the Follow-Up Note indicated Resident 1 refused vital signs.During a concurrent interview and record review on 2/20/2026 at 2:44 p.m. with Licensed Vocational Nurse (LVN) 1, reviewed Resident 1's care plans. LVN 1 stated that there was no care plan developed for Resident 1's refusal of care. LVN 1 stated a care plan should have been developed so staff would be aware of the resident's needs and know how to appropriately respond. LVN 1 stated having a care plan addressing refusal of care was important because the lack of one could place Resident 1 at risk for skin breakdown and the care plan serves as a communication tool for staff. During an interview on 2/20/2026 at 3:59 p.m., with the Director of Nursing (DON), the DON stated when a resident refuses care, a care plan should be developed to help guide the staff on how to direct care for the residents. During a review of the facility's policy and procedure (P&P) titled, "Care Plan Comprehensive," dated, 8/25/2021, the P&P indicated, "Each resident's comprehensive care plan is designed to incorporate identified problem areas and incorporate risk and contributing factors associated with identified problems. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes."	F0656		3/2/26
F0657 SS = D	Care Plan Timing and Revision	F0657		

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F0657 SS = D	Continued from page 3 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the care plan for one of three sampled residents (Resident 1) was revised to address fall prevention needs. The facility failed to: 1. Revised Resident 1's care plan to reflect the resident's current physical and cognitive (ability to think, understand, learn, and remember) status. This deficient practice had the potential to place Resident 1 at risk for preventable falls and inadequate supervision. Resident 1 subsequently experienced an unwitnessed fall on 2/20/2026, which resulted in multiple fractures (broken bone) to the left ribs. Findings:	F0657	**Corrective Action for Deficient Practice:** On 2/23/26, the Director of Nursing (DON) revised Resident 1's care plan to reflect the resident's current physical and cognitive status. On 2/23/26, the DON revised the "At risk for fall" care plan for Resident 1. **Identification of Other Affected Residents:** On 3/2/26, the DON reviewed the care plans for 5 residents with recent falls. There were no other residents identified to have been affected with the alleged deficient practice. **Systemic Changes:** On 3/2/26 the DON initiated an in-service to licensed nurses on the policy and procedure titled "Care Plan Comprehensive" with a focus on developing an "individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs." In addition, care plan interventions should be designed after careful consideration between the problem and it's cause. Interventions should address the underlying source of the problem rather than addressing only the symptoms. Monday through Friday, during the Clinical Meeting, the clinical team will review Change of Conditions from the day prior to identify any incidents of fall. The clinical team (Director of Nursing, Director of Staff Development, Infection Preventionist, Director of Rehab, Social Service Director) will conduct an audit of each resident's care plan that both the "Actual Fall" and the at "Risk for Fall" care plan are present and reflective of the resident's current condition and needs. The audit will also verify that a new intervention has been added as appropriate to address the relationship between the resident's problem areas and the cause of the fall. Negative findings will be corrected immediately. **Monitor to Ensure Ongoing Compliance and Responsible Individuals:** DON and/or designee will report findings of the care plan audits monthly x 3 months to QAA committee for further evaluation and recommendations. **Compliance Date:** 3/2/26	3/2/26

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F0657 SS = D	Continued from page 4 During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on 9/28/2026, with diagnosis including multiple rib fractures on the left side, dementia (loss of memory, language, problem-solving and other thinking abilities) and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 1's History and Physical (H&P), dated 9/28/2025, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 2/8/2026, the MDS indicated, Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 needed substantial/maximal assistance (helper does more than half the work) with activities of daily living (ADL's) like toileting and bathing. During a review of Resident 1's Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death), dated 1/11/2026, the COC indicated Resident 1 was found sitting on the floor next to her wheel chair (w/c). During a review of Resident 1's care plan titled "Risk for Falls" secondary to confusion/decreased safety awareness and history of falls (h/o)," dated 1/13/2026, the care plan indicated, to determine Resident 1's ability to transfer by herself, educate resident/representative on proper ambulation and transfer techniques, ensure call light is available to resident, evaluate environment to identify factors known to increase risk of falls, if a fall occurs alert provider and if fall occurs, initiate frequent neuro checks and bleeding evaluation per facility protocol. During a review of Resident 1's Interdisciplinary Care Conference Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care), dated 1/16/2026, the IDT indicated Resident 1 had a fall on 1/11/2026, the IDT indicated Resident 1 continued to be at risk for falls due to her cognition changes and dementia. The IDT indicated Resident 1's bed should be in lowest position, provide Resident 1 with a toileting schedule, provide a cup with holder to encourage	F0657		3/2/26

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F0657 SS = D	Continued from page 5 Resident 1 to drink fluids as she propels herself in her w/c to help prevent fatigue due to Resident 1's decreased safety awareness and educate the staff to ensure adherence to Resident 1's care plan. The IDT indicated to continue to monitor and adjust interventions as needed to promote residents safety and reduce fall risk. During a review of Resident 1's COC dated 2/20/2026 at 9:38 am, the COC indicated Resident 1 was found lying on her back in front of her bed on the floor. During a review of Resident 1's General Acute Care Hospital (GACH) record, dated 2/20/2026, the GACH record indicated Resident 1 was admitted to the GACH after an unwitnessed fall on 2/20/2026 that resulted in multiple fractures to the left ribs. During a concurrent interview and record review on 2/23/2026 at 11:23 a.m. with the Infection Preventionist (IP), Resident 1's care plan titled "Risk for Falls," dated 1/13/2026, and the Change of Condition (COC) report dated 1/11/2026, were reviewed. The IP stated the care plan should have been revised to reflect Resident 1 had an actual fall on 1/11/2026 and that a new plan of care should have been implemented. The IP stated that Resident 1's safety was at risk when the care plan was not updated following the fall on 1/11/2026. During an interview on 2/23/2026 at 2:45 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had an actual fall on 1/11/2026 and that the "Risk for Falls" care plan had not been revised to reflect this incident. The DON stated that no new interventions were added to Resident 1's care plan following the fall on 1/11/2026. The DON stated that revising a care plan after a fall was important because it identifies updated interventions and serves as an indicator of the care the resident should be receiving. During a review of the facility's policy and procedure (P&P) titled, "Care plan Comprehensive," dated 8/25/2021, the P&P indicated, "A individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are	F0657		3/2/26

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F0657 SS = D	Continued from page 6 identified in the comprehensive assessment. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident."	F0657		3/2/26