STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review, the facility failed to allowe bathing preference for five of five residents (Residents 13, 20, 59, 75, 92) This deficient practice had the potential to affect Resident's (Residents 13, 20, 59, 75, 92) quality of life. Findings: On 12/14/21, at 10:46 a.m., during Resident Council meeting Resident 59, and 88, two out of 13 alert and oriented residents who attended the meeting, stated rights of residents at this facility are not respected and encouraged. A review of Resident 59's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 09/22/2021, indicated the resident had intact cognitive skills (ability to think, understand and make daily decision) for daily decision making. A review of Resident 88 MDS dated [DATE] indicated the resident had intact cognitive skills for daily decision making. a. A review of Resident 13's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/8/2021, indicated the cognitive (the ability to understand or to be understood by others) skills for daily decisions making was intact, and total dependence with bathing with one-person physical assist (to help) and two persons assist for toilet use, locomotion and transfer. MDS indicated resident had an active diagnosis of diabetes mellitus ([DM] abnormal blood sugar), hypertension ([HTN] condition present when blood flows through the blood vessels with a force greater than normal), heart failure (a condition in which the heart has trouble pumping blood through the body), coronary artery disease ([CAD] a disease caused by cholesterol buildup in the wall of the major blood vessels that supply blood to the heart. During an interview on 12/20/21, at 9:54 a.m., Resident 13 stated shower was not provided on 12/13/21. Resident 13 stated Certified Nurse Assistant (CNA 10) was aware Resident 13 had to shower prior to treatment but CNA 10 told Resident 13 bed bath could only be provided because CNA 10 had too many residents to shower. Resident 13 stated Resident 13 felt disgusted and frustrated that Resident 13 cannot get a proper shower and had to settle with bed baths. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/21, at 2:22 p.m., CNA 14 stated sometimes they were so short staffed, CNAs were unable to take all residents to the shower room and were only able to provide bed baths. CNA 14 stated staffing issues were brought to the attention of Administrator (Admin) during a meeting when ASD was on vacation, but nothing was done. CNA 14 stated Resident 13 had verbalized showers were not being provided by CNA 10 on several occasions. During an interview on 12/21/at 10:00 a.m., ASD stated she usually made the CNA nursing assignment and there were plenty of days that staff called in sick and would ask staff to come in to work, but no one can work. ASD stated she did not try to reach out to registry (an agency that provides professional staff for temporary facility needs), because she was not aware if there was any registry and as far as she knows they do not use registry. ASD stated she notified the (DON) and Administrator (ADM) she did not have adequate staffing, but they were not able to provide additional staff and just have to work with the staff they have. During a concurrent interview and record review of Census and Nursing Hours per Patient Day ([NHPPD] form indicating projected daily nursing hours) for 12/13/2021 with Director of Nursing (DON) on 12/22/21 at 11:02 a.m., DON stated the NHPPD for 12/13/2021 was 3 and indicated they were not meeting the required 3.5 nursing hours on 12/13/2021 because they were short staffed: A review of All Facilities Letter (AFL) dated 1/23/18, indicated, effective July 1 ,2018, SB 97 (Chapter 52, Statutes 2017) requires SNFs, except those that are a distinct part of general acute care or a state- owned hospital or development center, to provide a minimum of 3.5 direct care service hours per patient day, with a minimum of 2.4 performed by certified nurse assistants. b. During an interview on 12/20/21, at 11:17 a.m., Resident 59 stated a shower schedule change request was made to ASD on several occasions so Resident 59 will be able to shower prior to attending dialysis visits on Mondays, Wednesdays, and Fridays, but request was denied by ASD due to staffing issues. Resident 59 stated additional showers were not granted because of staffing issues. Resident 59 stated this made Resident 59 feel dirty and embarrassed because dialysis staff have mentioned on several occasions to Resident 59 they prefer Resident 59 to come to visits showered and clean and they ask Resident 59 why Resident 59 wasn't showered on dialysis days. During an interview on 12/19/201 12:50 p.m. CNA 23 stated they are sometime short staff and when they were short staff, they ended up having 10 to 11 residents and that workload was heavy. They cannot provide shower as schedule and will only shower alert resident because they will complain and those who are not alert don't get shower even if they were scheduled to be shower. During an interview on 12/19/2021, at 1:00 p.m. CNA 22 stated facility was short staffed, and CNA sometimes have 11 residents each when they normally have 8 for day shift and were not able to shower resident as scheduled. They only shower alert resident because they will complain but unable to shower those who are not alert and can only give bed bath because showers takes too long and they cannot accommodate residents request to be showered when it was not their shower day. Giving shower takes about an hour specially when they have to use lift machine. Resident 20 and Resident 59 will request to be shower but we cannot grant their request because our workload was heavy when we are short staff and told the residents they cannot honor their request. CNA 22 stated they follow the shower days based on bed location and not on residents needs or preference because with short staff it was hard to accommodate residents' request. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/21/21 at 07:30 a.m., LVN 5 stated that starting October 2021 Staffing issues was bad and there were times CNAs have 12 each when they were only supposed to have 8 and they were not able to shower residents. Resident 59 shower schedule were Wednesday, Saturday and Sundays and she goes to dialysis Monday, Wednesday, and Friday. She was requesting to be showered when she goes to Dialysis, but some CNAs were not able to shower her because of short staffing. I agree that residents should be showered when they go to dialysis because dialysis residents were prone to infection, and we don't want the resident to get infection and our staffing should be improved so the CNAs can have enough time to perform their duties. A record review of Resident 59's Bathing record for December 2021 indicated Resident 59 did not received a bath/shower/ bed bath on her dialysis days on 12/1/2021, 12/3/2021, 12/5/2021, 12/8/2021, 12/13/2021, and 12/15/2021. During a review of the facility's policy and procedure titled, Resident Self Determination and Participation, dated February 2021, indicated 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 and personal care needs, such as bathing schedules bathing methods, grooming and styles of dress. During a concurrent interview and record review of Facility Assessment form dated 10/27/2021, DON stated record indicated general staffing plan to ensure sufficient staff to meet the needs of the residents at any given time was direct care staff ratio was 1 CNA is to 8 residents' ratio for day shift, 1 is to 12 residents' ratio for evening shift and 1 CNA to 14 residents' ratio for night shift for Skilled Nursing Facility. c. A review of the Admission Records indicated Resident 75 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses not limited to paraplegia (loss of the ability to move the legs and lower body), seborrheic dermatitis (a skin condition that causes dry, flaky patches and red skin, mainly on the scalp), major depressive disorder ([MDD] a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating or working), obesity (excess body fat). During a concurrent observation and interview on 12/13/21 at 10:58 a.m., at Resident 75's room, Resident 75 was observed moving his head side to side on pillow and complaining his head and back were very itchy. Resident 75 stated he was very uncomfortable and hated that his head, back and buttocks get itchy all the time. Observed CNA 9 turn Resident 75 to the right side to scratch Resident 75's head and back and noticed Resident 75 had red, dry patches of skin on entire back and buttocks. During an interview on 12/13/21 at 11:00 a.m. with CNA 9, CNA 9 stated Resident 75 has rashes all over his back and buttocks. CNA 9 stated that Resident 75 frequently asks to get his back scratched. CNA 9 stated treatment nurses put cream on Resident 75's back to help with the itchiness and rash but Resident 75 still complains of frequent itchiness. During an interview on 12/22/21 08:43 a.m., Resident 75 stated he wanted to be showered but they told him he cannot shower because he was too big. Resident 75 stated they do not shower him and only gets bed bath. Resident 75 stated he wanted to feel better and treat his rashes because he was itchy and felt uncomfortable without shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2022, at 09:30 a.m., LVN 12 stated Resident 75 have rashes covering almost entirely his back and buttocks due to perspiration and his rashes gets worse during summertime because of heat. LVN 12 stated Resident 75 wanted to have shower and she was frustrated because she also wanted Resident 75 to have a shower, but the CNAs (did not specify name) response was how when he was overweight, too heavy as he weighs about 348 pounds (unit of measurement) and might fall. LVN 12 stated showering is very important to ensure to provide good skin care and assess skin condition, but facility was short staff and does not have enough CNA to be able to shower all residents. LVN 12 stated the DON was aware Resident 75 was not being showered and only getting bed bath. During an interview 12/22/2021 at 11:45 a.m., DON stated Resident 75 was being provided bed bath only because of his weight and unable to provide reason why resident cannot be showered and stated there was no contraindication for Resident 75 to be showered and CNAs should be able to shower resident and will ensure resident gets shower. A review of facility's policy and procedure (P/P) titled Bath, Shower/Tub Program, dated revised February 2018, indicated the purpose of this procedure are to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. Document the date and time the shower/tub bath was performed. The name and title of the individual(s) who assisted the resident with the shower/tub. All assessment data (example any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. If the resident refused the shower/tub bath, the reason. d. During an interview on 12/16/21, at 11:08 a.m., Resident 92 stated on one occasion Resident 92 wanted to shower prior to going out on pass for unspecified day and unnamed staff told her she does not have enough time to shower Resident 92 because the facility was short staffed. Resident 92 stated shower wasn't offered later in the day. Resident 92 stated lack of shower made Resident 92 feel embarrassed, disgusted, and dirty. During an interview on 12/17/21, at 9:52 a.m., Assistant Staff Developer (ASD), stated there was no written shower schedule policy. ASD stated residents should be able to change shower schedules and request for extra showers on nonscheduled days if staffing permits. ASD stated there were days they were short staffed, unable to find replacement and as a result staff were not able to make at least every two hours rounds because of heavy workload. A lot of residents were mad because we cannot attend to their needs timely. There was a Human Resource who came but nothing changed. ASD stated she agreed that facility was short staff and staffing needed to be improved, staff were tired and can get hurt when overworked and some may choose not to stay when overworked. During an interview on 12/17/21, at 2:22 p.m., with CNA 14, CNA 14 stated during the months of October and November, CNA morning shift was short staffed. CNA 14 stated on several occasions, he couldn't take several of the residents to the shower room and was only able to provide bed baths. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 12/22/2021 at 11:45 a.m., DON stated all residents on Skilled Nursing Facility should be able to shower on their scheduled shower day and if anyone request for shower a preferred shower day, they should be allowed an opportunity to exercise his or her autonomy regarding those things that were important in his or her life including the residents' interests and preferences. DON stated showering was important to promote cleanliness, good hygiene and help improve skin condition. During a review of the facility's policy and procedure titled, Resident Rights, dated December 2016, indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to self-determination, be supported by the facility in exercising his or her rights and participate in his or her care planning and treatment.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41699 Based on observations, interview, and record review, the facility failed to implement its written abuse prevention policy and procedure, including: 1. Investigating alleged incidents of abuse, when one (1) of two (2) residents (Resident 9) alleged that Certified Nurse Assistant 3 (CNA 3) had a fist fight with Resident 9 and Certified Nurse Assistant 2 (CNA 2) had wrung a towel soaked with hot water over Resident 9's genitals (a person's external organs for reproduction). 2. Ensuring CNA 3 and CNA 2 were suspended pending completion of an abuse investigation. 3. Reporting the results of the investigation of alleged abused perpetuated by CNA 3 and CNA 2 to the State Survey Agency (Department) within five (5) days. These deficient practices had the potential to result in an unidentified abuse of all residents who were assigned to CNA 3 and 2 and placed resident 9 at risk for the potential of ongoing abuse and resulted in Resident 9's feeling of intimidation, retaliation and neglect, and a decline in emotional wellbeing. On 12/21/2021, at 3:08 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident or residents) was identified and declared under F607. The facility's Administrator (ADM) was notified of the need for immediate action and seriousness of other residents' and staff members health and safety being threatened for failure to implement written policies for abuse to investigate an allegation of abuse (by Resident 9), prevent further potential abuse by failing to remove the alleged perpetuator (CNA 3 and CNA 2) while investigation was in progress, and follow policies for reporting the results of the investigation of the abuse to the Department. On 12/22/2021, at 11:32 a.m., the ADM and the facility's Nurse Consultant were informed that the IJ situation was removed after the implementation of the acceptable Plan of Action ([POA], interventions to correct the deficient practice) was verified while on onsite through observation, interview, and record review. Cross-reference F610. Findings: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the Face Sheet (admission record), dated 12/17/2021, the Face Sheet indicated the facility admitted Resident 9 on 7/22/2021, with diagnoses including, pneumonia (infection of the lungs), hypertension (high blood pressure), anemia (a condition in which the blood doesn't have enough healthy red blood cells that carry oxygen to the body's organs), diabetes mellitus (disorder where the body does not produce enough or respond normally to insulin, which allows your body to use sugar for energy), acute respiratory failure (lung injury that allows fluid to leak into the lungs), tracheostomy (an opening surgically created through the neck into the windpipe to allow for a breathing tube), dysphagia (difficulty swallowing food or liquids), and a gastrostomy (a surgical opening in the abdominal wall into the stomach). During a review of the Minimum Data Set (MDS, a comprehensive assessment and care screening tool), dated 7/4/2021, the MDS indicated Resident 9 had intact cognitive (process of acquiring and understanding knowledge) response. The MDS indicated Resident 9 was totally dependent on staff for bed mobility, transfer, toileting, eating, and personal hygiene. During an interview, on 12/13/21, at 11:35 a.m., with Resident 9, Resident 9 stated she suffered pain after CNA 3 pulled the towel under her buttocks real hard during incontinence care on 11/28/2021 at 2:00 a.m. Resident 9 stated a fist fight happened between her and CNA 3 because CNA 3 forced Resident 9 to be cleaned, despite her objections. Resident 9 stated she did not report the fist fight between her and CNA 3 to staff but reported the incident (date and time unknown) to her family member (FM3). Resident 9 stated there was another incident (date and time unknown) of abuse where CNA 2 burned Resident 9 by wringing a towel soaked with hot water over her private parts. Resident 9 stated she reported the incident where CNA 2 burned her genitals to FM3. During an interview on 12/13/21, at 11:40 a.m., with FM3, FM3 stated ADM was notified (date and time unknown) of the allegations of abuse (from CNA 3 and CNA 2). FM3 stated that the ADM told FM3 that it [the alleged abuse of Resident 9 by CNA 3 and 2] will be taken care of. During an interview on 12/14/2021, at 12:44 p.m., with ADM, ADM stated he was not aware of the alleged abuse incidents where Resident 9 was allegedly abused by CNA 3 and 2. ADM acknowledged that he was now made aware of an abuse allegation where Resident 9 alleges that CNA 3 and CNA 2 were abusive towards Resident 9. Administrator stated he would try to look at it. During an observation on 12/16/2021 at 03:15 p.m., Resident 9 was observed talking to LVN 7. Resident 9 was observed informing LVN 7 that she had a fist fight with CNA 3 and that something must be done. Resident 9 stated, while emotional and crying, that the incident made her feel like she is less of a person. Resident 9 stated that she wanted to go home because she's scared for her life; that CNA 3 will continue the abuse. Resident 9 stated she did not tell anybody about the incident (the fist fight between Resident 9 and CNA 3 and CNA 2 burning Resident 9) because she felt like the staff would retaliate against her. Resident 9 stated she reported abuse by CNA 3 and CNA 2 to FM3 and FM3 made complaints to ADM. LVN 7 stated that if any resident complained about abuse, the abuse coordinator must investigate the allegation and the staff involve must be taken away from the assignment. LVN 7 stated he will take care and look about it [report to the abuse coordinator the alleged abuse]. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/21/2021, at 9:34 a.m. with Resident 9, Resident 9 stated CNA 3 was assigned to her last night (12/20/21 at 11:00 p.m. to 12/21/21 at 7:00 a.m.). Resident 9 stated she was really scared and wanted to go home. Resident 9 stated she felt intimidated and neglected by the abuse incidents perpetuated by CNA 3 and CNA 2. During a concurrent interview and record review, on 12/21/2021, at 10:30 a.m., with Assistant Staff Developer (ASD), the assignment sheet and clock-in record from 12/17/2021 to 12/20/2021 were reviewed. ASD stated CNA 3 was scheduled and signed-in to work on 12/17/2021 from 7:00 p.m. to 7:00 a.m. and was assigned to Resident 9. CNA 3 also clocked-in again on 12/17/2021 at 10:29 pm and clocked out on 12/18/2021 at 6:30 am (CNA 3 worked a double shift). CNA 3 was scheduled and signed-in to work on 12/20/2021 from 10:30 p.m. to 6:30 a.m. and was assigned to Resident 9. During a concurrent interview and record review on 12/21/2021, at 12:44 a.m., with ADM, the facility's policies titled Resident Safety and Prevention from Potential Abuse and Resident 9's medical records were reviewed. ADM stated that there is no documented evidence CNA 3 and CNA 2 allegedly abused Resident 9 or that an investigation began. ADM stated he could not explain why he did not start the investigation of Resident 9 abuse allegations. ADM stated social services and himself would initiate the investigation and conduct interviews with staff, resident, resident family and commence self-report within 2 hours for allegation of staff to resident abuse report the alleged incidents of abuse to the ombudsman, local law enforcement. ADM stated that the results of the investigation would be submitted to the Department within 5 days. ADM stated the facility did not follow the abuse policy by immediately investigating Resident 9's allegations of abuse perpetuated by CNA 3 and CNA 2 when ADM was made aware of the alleged abuse on 12/14/2021, immediately suspend CNA 3 and CNA 2, and report the results of the investigation to the Department within 5 days. ADM stated immediately investigating abuse allegations, suspending the alleged perpetrators, and reporting abuse allegations and the conclusion of the investigations are important because it can prevent ongoing abuse, psychosocial harm, and retaliation for the alleged perpetrators and other staff. During an interview on 12/22/2021, at 9:22 a.m., with the Social Services Assistant (SSA), SSA stated if any resident alleges abuse, the alleged abuse must be reported to the abuse coordinator, ADM. SSA stated all allegations of abuse must be investigated, so that we will know which staff is responsible. SSA stated that all staff are mandated to report any form of abuse. During an interview on 12/22/2021, at 9:35 a.m., with the Social Services Director (SSD), the SSD stated that allegations of abuse from residents must be reported to the abuse coordinator, ADM, immediately. The SSD stated that reporting the alleged abuse to the abuse coordinator ensures that the abuse will be investigated properly. During an interview on 12/22/2021 at 11:01 a.m., with the Director of Nursing (DON), the DON stated that every abuse allegation must be investigated timely because that is a reportable incident, and we need to know the truth about the abuse. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's P/P titled, Abuse Prevention Program dated revised December 2016, the P/P indicated: the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion. verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. As part of the abuse prevention, the administrator: Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. During a review of the facility's P/P titled, Abuse Investigation and Reporting dated revised July 2017, the P/P indicated: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reponed. Role of the Administrator: If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. The administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Reporting: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing the facility, the local/State Ombudsman, The Resident's Representative (Sponsor) of Record, Adult Protective Services (where state law provides jurisdiction in long-term care), Law enforcement officials, The resident's attending physician; and, The facility medical director. During a review of the facility's P/P titled, Abuse Investigation and Reporting dated revised July 2017, the P/P indicated: The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within (5) working days of the occurrence of the incident.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on record review and interview, the facility failed to ensure the resident was not subjected to a physical abuse from a Certified Nursing Assistant (CNA 2) and CNA 3, failed to investigate the alleged abuse, protect the resident from possible further abuse, and report the results of investigation to the officials in accordance with State Law for one of two sampled residents (Resident 9). The facility failed to: 1. Conduct the investigation of Resident 9's allegation of physical abuse. Resident 9 alleged that CNA 3 had a fist fight with Resident 9 and CNA 2 had wrung a towel soaked with hot water over Resident 9's genitals (a person's external organs for reproduction). 2. Suspend the alleged perpetrators, CNA 3 and CNA 2, per facilities policy titled Abuse Investigation Reporting. 3. Ensure CNA 3 and CNA 2 were not assigned to continue to care for Resident 9 after the allegation of abuse by both CNAs was made. 4. Report Resident 9's allegation of physical abuse to the State Survey Agency Licensing & Certification (L&C) Department immediately and report the results of all investigations within 5 working days to officials in accordance with State law, including to the State Survey Agency and L&C Department. These deficient practices placed Resident 9 at risk for the potential of ongoing abuse and resulted in Resident 9's feeling of intimidation, retaliation, neglect, and a decline in emotional wellbeing. On 12/21/2021, at 3:08 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident or residents) was identified and declared. The facility's Administrator (ADM) was notified of the immediacy and seriousness of other residents' and staff members health and safety being threatened for failure to investigate an allegation of abuse (by Resident 9), prevent further potential abuse by failing to remove the alleged perpetuator (CNA 3 and CNA 2) while investigation was in progress and report the results of the investigation of the abuse to the State Survey Agency L&C Department. On 12/22/2021, at 11:32 a.m., the ADM and the facility's Nurse Consultant were informed that the IJ situation was removed after the implementation of the acceptable Plan of Action ([POA], interventions to correct the deficient practice) was verified while on onsite through observation, interview, and record review. Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	12/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the Face Sheet (admission record), dated 12/17/2021, the Face Sheet indicated Resident 9 was admitted to the facility on [DATE], with diagnoses including pneumonia (infection of the lungs), hypertension (high blood pressure), anemia (a condition in which the blood doesn't have enough healthy red blood cells that carry oxygen to the body's organs), diabetes mellitus (disorder where the body does not produce enough or respond normally to insulin, which allows your body to use sugar for energy), acute respiratory failure (lung injury that allows fluid to leak into the lungs), tracheostomy (an opening surgically created through the neck into the windpipe to allow for a breathing tube), dysphagia (difficulty swallowing food or liquids), and a gastrostomy (a surgical opening in the abdominal wall into the stomach). During a review of Resident 9's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool), dated 7/4/2021, the MDS indicated Resident 9 had intact cognitive (process of acquiring and understanding knowledge) skills for daily decision making. The MDS indicated Resident 9 was totally dependent on staff for bed mobility, transfer, toileting, eating, and personal hygiene. During an interview, on 12/13/21, at 11:35 a.m., Resident 9 stated she suffered pain after CNA 3 pulled the towel under her buttocks real hard during incontinence care on 11/28/2021 at 2:00 a.m. Resident 9 stated a fist fight happened between her and CNA 3 because CNA 3 forced Resident 9 to be cleaned, despite her objections. Resident 9 stated she did not report the fist fight between her and CNA 3 to staff but reported the incident (date and time unknown) to her family member (FM3). Resident 9 stated there was another incident (date and time unknown) of abuse where CNA 2 burned Resident 9 by wringing a towel soaked with hot water over her private parts (genitals). Resident 9 stated she reported the incident where CNA 2 allegedly burned her genitals to FM3. During an interview on 12/13/21, at 11:40 a.m., FM3 stated ADM was notified (date and time unknown) of the allegations of abuse (from CNA 3 and CNA 2). FM3 stated that the ADM told FM3 that it [the alleged abuse of Resident 9 by CNA 3 and 2] will be taken care of. During an interview on 12/14/2021, at 12:44 p.m., ADM stated he was not aware of the alleged abuse incidents where Resident 9 was allegedly abused by CNA 3 and CNA 2. ADM acknowledged that he was now made aware of an abuse allegation where Resident 9 alleges that CNA 3 and CNA 2 were abusive towards Resident 9. Administrator stated he would try to look at it. During an observation on 12/16/2021 at 3:15 p.m., Resident 9 was observed talking to LVN 7. Resident 9 was observed informing LVN 7 that she had a fist fight with CNA 3 and that something must be done. Resident 9 stated, while emotional and crying, that the incident made her feel like she is less of a person. Resident 9 stated that she wanted to go home because she was scared for her life and that CNA 3 will continue to abuse her. Resident 9 stated she did not tell anybody about the incident (the fist fight between Resident 9 and CNA 3 and CNA 2 burning Resident 9) because she felt like the staff would retaliate against her. Resident 9 stated she reported abuse by CNA 3 and CNA 2 to FM3 and FM3 informed ADM. LVN 7 stated that if any resident complained about abuse, the abuse coordinator must investigate the allegation and the staff involved must be taken away from the assignment. LVN 7 stated he will take care and look about it [report to the abuse coordinator the alleged abuse]. During an interview on 12/21/2021, at 9:34 a.m. Resident 9 stated CNA 3 was assigned to her last night (12/20/21 at 11:00 p.m. to 12/21/21 at 7:00 a.m.). Resident 9 stated she was really scared and wanted to go home. Resident 9 stated she felt intimidated and neglected by the abuse incidents perpetuated by CNA 3 and CNA 2. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review, on 12/21/2021, at 10:30 a.m., with Assistant Staff Developer (ASD), the assignment sheet and clock-in record from 12/17/2021 to 12/20/2021 were reviewed. ASD stated CNA 3 was scheduled and signed-in to work on 12/17/2021 from 7:00 p.m. to 7:00 a.m. and was assigned to Resident 9. CNA 3 also clocked-in again on 12/17/2021 at 10:29 pm and clocked out on 12/18/2021 at 6:30 am (CNA 3 worked a double shift). CNA 3 was scheduled and signed-in to work on 12/20/2021 from 10:30 p.m. to 6:30 a.m. and was assigned to Resident 9. During a concurrent interview and record review on 12/21/21, at 12:44 a.m., with ADM, Resident 9's medical record was reviewed. ADM stated he did not investigate Resident 9's allegation of abuse from CNA 3 and CNA 2 when the allegations of abuse were reported to him on 12/14/21. ADM stated that there is no documented evidence CNA 3 and CNA 2 allegedly abused Resident 9 or that an investigation began. ADM stated it is important to begin an investigation once an allegation of abuse is made because it can keep the resident safe by preventing ongoing abuse and possible retaliation. ADM stated he should have suspended CNA 3 and CNA 2 while an investigation took place to prevent ongoing abuse, but he did not. ADM stated the results of the investigation of the alleged abuse perpetuated by CNA 3 and CNA 2 were not reported to State Survey Agency L&C Department within 5 working days of incident because an investigation into both incidents did not begin. ADM stated he did not have an excuse for not investigating and reporting to the Department Resident 9's allegation of abuse perpetuated by CNA 3 and CNA 2. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting revised July 2017, indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Role of the Administrator: If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. The administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The administrator will keep the resident and his/her representative informed of the progress of the investigation. The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.