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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 44055 Based on interview and record review the facility failed to ensure one of one resident's (Resident 1) family was informed that Resident 1 had an enabler bar (a structural support attached to the frame of the bed used as an assistive device) attached to her bed and the risks and benefits for using such device. This deficiency violated resident 1 or her legarl representative's right to make an informed decision regarding the use of the enabler bar. Findings: A review of the Resident 1s admission record (face sheet) indicated the facility admitted Resident 1 on 2/25/2022. Resident 1's diagnoses included cerebral infarction (disrupted blood flow in the brain leading to brain damage), muscle wasting (thinning) and atrophy (overall loss of muscle mass), type 2 diabetes (body cannot process glucose[blood sugar] properly), depression (mood disorder characterized by persistent sadness or loss of interest affecting daily life), cirrhosis of the liver (late stage of scarring (fibrosis) of the liver[organ in body helps digest food, store energy, and remove poisons]), liver transplant status (resident had her diseased liver replaced with a healthy liver), convulsions (general term for uncontrollable muscle contractions), and hemiplegia (paralysis of one side of the body). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/27/2022, the MDS indicated Resident 1 had severely impaired cognitive (ability to learn, remember, understand, and make decision) skills for daily decision making. Resident 1 needed limited assistance (resident highly involved in activity staff guided)with eating; and total dependence with bed mobility, transfer, toilet use, and personal hygiene. Resident 1 required one person's physical assistance with personal hygiene, bed mobility, eating, and toilet use. A record review of the 911 call received on 2/27/2022 at 6:36 a.m., indicated the caller stated Resident 1 fell and her arm got caught between the bed and the siderail and it seems like it's broken. A record review of Resident 1's Transfer Form dated 2/27/2022 at 7:02 a.m. indicated Resident 1 was discharged to the hospital. Per transfer form, Resident 1 was found in room on left side of bed on floor on top of blanket/pillow with left arm entangled in enabler bar. (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

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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with licensed vocational nurse 1 (LVN 1) and a review of Resident 1's change of condition (COC) evaluation (dated 2/27/2022at 6:30 a.m.) on 3/10/2022 at 4:56 a.m., LVN 1 confirmed that on 2/27/2022 at 6:30 a.m., housekeeper 1 (HK 1) called her to report Resident 1 fell and LVN 1 came into the room and noted Resident 1 on the left side of the bed on the floor on top of a blanket and pillow with discolored left arm entangled in the enabler bar. Per LVN 1 the bed was in high position and the head of bed (HOB)at a 90 degree angle. Per LVN 1, her left arm was between the bed frame and under the bottom opening of the enabler bar and she had looped it up to the middle opening and her arm was looped into the top hole of the enabler bar; It was as if her arm was sewn onto the enabler bar gaps. During an interview with medical records (MR) on 3/11/2022at 10:39 a.m., MR confirmed Resident 1 had no signed informed consent (written permission granted in the knowledge of benefits and possible consequences of treatment rendered) for the enabler bar used in her electronic and physical chart. During a concurrent interview with the Minimum Data Set coordinator (MDSC) and record review of Resident 1's medical records on 3/11/2022 at 11:23 a.m., MDSC confirmed Resident 1 fell and left arm was entangled on an enabler bar on 2/27/2022. Per MDSC, after reviewing Resident 1's medical records, no documented evidence of an enabler bar informed consent signed by the responsible party or resident can be provided. During an interview with the director of nursing (DON) on 3/11/2022 at 1:02 p.m., the DON stated he was aware an informed consent was not obtained prior to Resident 1 using the bed with the enabler bar. Per DON, enabler bar resident usage entailed the need for staff to obtain informed consent prior to use. A record review of the facility's policy titled, Proper use of side rails (revised 12/2016), indicated the purpose of these guidelines were to ensure the safe use of side rails as mobility device. Per policy, consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol with risks and benefits addressed. Further, documentation will indicate if less restrictive approaches were not successful, prior to considering the use of side rails. The risks and benefits of side rails will be considered for each resident.

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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44055 Based on interview and record review the facility failed to follow their policy and procedure (P&P), Proper use of Side Rails (structural support attached to the frame of the bed used as an assistive device), for one of one sampled resident (Resident 1) by failing to: 1. Assess Resident 1 for risk of entrapment (an occurrence involving a resident who is caught, trapped, or entangled in the hospital bed system), for proper use of side rails prior to resident 1's use of the side rails. 2. Ensure side rail entrapment zones (any open space where an individual can become caught by their body part in the tight spaces around the bed rail or bedside mobility aid) were measured prior to installation and use. These deficient practices resulted in the entrapment of Resident 1's left arm, in between the side rails and the bed frame, sustaining a left humeral neck fracture (broken bone of left upper arm). Findings: During a review of the Resident 1's admission record (face sheet), the face sheet indicated the facility admitted Resident 1 on 2/25/2022. Resident 1's diagnoses included cerebral infarction (disrupted blood flow in the brain leading to brain damage), muscle wasting (weakening, shrinking, and loss of muscle caused by disease or lack of use) and atrophy (overall loss of muscle mass),Type 2 Diabetes (body cannot process glucose[blood sugar] properly), depression (mood disorder characterized by persistent sadness or loss of interest affecting daily life), cirrhosis of the liver (late stage scarring of the liver[organ in body helps digest food, store energy, and remove poisons]), liver transplant status (resident had her diseased liver replaced with a healthy liver), convulsions (general term for uncontrollable muscle contractions), and hemiplegia (paralysis) of left side of the body. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/27/2022, the MDS indicated Resident 1 had severely impaired cognitive (ability to learn, remember, understand, and make decision) skills for daily decision making. Resident 1 needed limited assistance (resident highly involved in activity guided by staff) with eating, and total dependence with bed mobility, transfer, toilet use, and personal hygiene. A record review of the 911 call from the facility, received on 2/27/2022 at 6:36 a.m., indicated, the caller stated, Resident 1 fell and her arm got caught between the bed and the siderail and it seems like it's broken. A record review of Resident 1's Transfer Form dated, 2/27/2022 at 7:02 a.m., indicated Resident 1 was discharged to the hospital. Per transfer form, Resident 1 was found in her room on left side of the bed on floor, on top of a blanket/pillow with the resident's left arm entangled in the siderail. (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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 3/10/2022 at 4:56 p.m., with licensed vocational nurse 1 (LVN 1) of Resident 1's Change of Condition (COC) evaluation, dated 2/27/2022 at 6:30 a.m., the COC indicated housekeeper 1 (HK 1) called LVN 1 to report Resident 1 fell and LVN 1 came into the room and noted Resident 1 on the floor, on the left side of the bed, on top of a blanket and pillow with a discolored (changes in skin color due to injury or illness) left arm entangled in the side rail. LVN 1 stated the bed was in high position and the head of bed (HOB) at a 90-degree angle (HOB was raised straight up). LVN 1 stated, Resident 1's left arm was threaded between the bed frame, the bottom, middle and top opening of the side rail. It was as if her arm was sewn onto the side rail bar gaps. During a phone interview with registered nurse 1 (RN 1) on 3/11/2022 at 6:15 am., RN 1 stated that on the morning of 2/27/2022, upon response to Resident 1's reported fall, Resident 1's bed was noted to be elevated all the way up and the HOB at a 90-degree angle. RN 1 stated Resident 1 was facing the bed, hanging from her left arm on the left side of the bed and half her body was on the floor under the bed. RN 1 stated Resident 1's left arm was stitched or sewn in between the bed frame and the side rail. Her arm went through the bedframe and side rail, then it was threaded into the middle opening, and top opening. After much difficulty, RN 1 stated, facility staff had to release the side rail to free Resident 1 from being entangled, right before 911 responders came. RN 1 stated, in this situation, the side rail was a hazard. A record review of Resident 1's history and physical ([H&P]: initial clinical evaluation and examination of resident) dated 3/1/2022, the H&P indicated, on 2/27/2022, Resident 1 was diagnosed with left humoral neck fracture in the emergency department after sustaining a fall. During an interview with medical records staff (MR staff) on 3/11/2022 at 10:39 a.m., MR staff stated Resident 1 had no assessment for side rail usage, no physician order for side rail usage, no care plan for side rail usage, and no consent from the family for use of side rails. During a concurrent interview and record review, on 3/11/2022 at 11:23 a.m., with the Minimum Data Set coordinator (MDSC) after reviewing Resident 1's medical record, MDSC stated Resident 1 fell and her left arm was entangled in the side rails on 2/27/2022. MDSC stated, there was no documented evidence that a siderail assessment was completed, a physician order for the side rails, a care plan, and informed consent were completed. During an interview with maintenance director (MNT) on 3/11/2022 at 12:04 p.m., MNT stated they (facility's staff) did not have any measurements of entrapment zones for the beds and the side rails in the facility. During an interview with the director of nursing (DON) on 3/11/2022 at 1:02 p.m., the DON stated he was aware Resident 1 did not have side rail assessment, physician order for the device, did not have care plans developed and implemented for the side rails, and did not have informed consent for use of side rails. DON stated, use of side rails (for residents) entailed the need for an assessment, orders, care plans and a consent prior to use. DON stated, the side rail can be a hazard to residents; therefore, there's a process in place before using the device. During an interview with DON on 3/11/2022 at 1:02 p.m., the DON stated there was no documented evidence that entrapment zone areas for the bed and side rails, prior to side rail usage for Resident 1, had been measured in the facility. (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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview with the administrator (ADM) on 3/11/2022 at 1:33 p.m., ADM stated that he does not know anything about entrapment zone measurements being completed by the facility prior to side rail usage. A record review of the facility's policy titled, Proper use of Side Rails (revised 12/2016), indicated the purpose of these guidelines were to ensure the safe use of side rails as mobility device. Per policy, an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility; ability to change positions, transfer to and from bed or chair, and to stand and toilet; risk of entrapment from the use of side rails; and bed's dimensions are appropriate for the resident's size and weight; and use of side rails as an assistive device will be addressed in the resident care plan. Consent for using devices will be obtained from the resident or legal representative per facility protocol with risks and benefits addressed. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used). Documentation will indicate if less restrictive approaches were not successful, prior to considering the use of side rails. The risks and benefits of side rails will be considered for each resident.

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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44055 Based on interview and record reviews the facility failed to develop and implement, for one of one residents (Resident 1), a person centered care plan for fall safety precautions by not developing a care plan to ensure proper usage of the enabler bar (a structural support attached to the frame of the bed used as an assistive device) to prevent accidents. This deficient practice potentially contributed to Resident 1's fall and entanglement in the enabler bar. Findings: A review of the Resident 1s admission record (face sheet) indicated the facility admitted Resident 1 on 2/25/2022. Resident 1's diagnoses included cerebral infarction (disrupted blood flow in the brain leading to brain damage), muscle wasting (thinning) and atrophy (overall loss of muscle mass), type 2 diabetes (body cannot process glucose[blood sugar] properly), depression (mood disorder characterized by persistent sadness or loss of interest affecting daily life), cirrhosis of the liver (late stage of scarring (fibrosis) of the liver[organ in body helps digest food, store energy, and remove poisons]), liver transplant status (resident had her diseased liver replaced with a healthy liver), convulsions (general term for uncontrollable muscle contractions), and hemiplegia (paralysis of one side of the body). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/27/2022, the MDS indicated Resident 1 had severely impaired cognitive (ability to learn, remember, understand, and make decision) skills for daily decision making. Resident 1 needed limited assistance (resident highly involved in activity staff guided)with eating; and total dependence with bed mobility, transfer, toilet use, and personal hygiene. Resident 1 required one person's physical assistance with personal hygiene, bed mobility, eating, and toilet use. A record review of the 911 call received on 2/27/2022 at 6:36 a.m., indicated the caller stated Resident 1 fell and her arm got caught between the bed and the siderail and it seems like it's broken. A record review of Resident 1's Transfer Form dated 2/27/2022 at 7:02 a.m. indicated Resident 1 was discharged to the hospital. Per transfer form, Resident 1 was found in room on left side of bed on floor on top of blanket/pillow with left arm entangled in enabler bar. During a concurrent interview with licensed vocational nurse 1 (LVN 1) and a review of Resident 1's change of condition (COC) evaluation (dated 2/27/2022at 6:30 a.m.) on 3/10/2022 at 4:56 a.m., LVN 1 confirmed that on 2/27/2022 at 6:30 a.m., housekeeper 1 (HK 1) called her to report Resident 1 fell and LVN 1 came into the room and noted Resident 1 on the left side of the bed on the floor on top of a blanket and pillow with discolored left arm entangled in the enabler bar. Per LVN 1 the bed was in high position and the head of bed (HOB)at a 90 degree angle. Per LVN 1, her left arm was between the bed frame and under the bottom opening of the enabler bar and she had looped it up to the middle opening and her arm was looped into the top hole of the enabler bar; It was as if her arm was sewn onto the enabler bar gaps. (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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with medical records (MR) on 3/11/2022 at 10:39 a.m., MR confirmed Resident 1 had no care plan for the enabler bar used. During a concurrent interview with the Minimum Data Set coordinator (MDSC) and record review of Resident 1's medical records on 3/11/2022 at 11:23 a.m., MDSC confirmed Resident 1 fell and her left arm was entangled on an enabler bar on 2/27/2022. Per MDSC, after reviewing Resident 1's medical records, no documented evidence of an enabler bar care plan can be provided. During an interview with the director of nursing (DON) on 3/11/2022 at 1:02 p.m., the DON stated he was aware Resident 1did not have care plans developed and implemented for the enabler bars. Per DON, enabler bar resident usage entailed the need for a care plan prior to use. During a concurrent interview with the administrator (ADM) and record review of social services progress notes (dated 2/28/2022 at 12:32 p.m.) on 3/11/2022 at 1:33 p.m., ADM confirmed that per case manager from the acute care facility, Resident 1 reported that she was reaching for the phone when she fell ; ADM also confirmed, Resident 1's daughter confirmed that Resident 1 fell because she was reaching for her phone which was out of reach. A record review of Resident 1's care plan initiated 2/25/2022 for resident's risk for unavoidable falls with injury related to limited mobility indicated resident needed a safe environment with personal items within reach. It also indicated staff needed to anticipate Resident 1's needs. A record review of the facility's policy titled, Proper use of side rails (revised 12/2016), indicated the purpose of these guidelines were to ensure the safe use of side rails as mobility device. Per policy, use of side rails as an assistive device will be addressed in the resident care plan.

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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44055 Based on observation, interview and record review the facility failed to ensure the licensed vocational nurse 2 and 3 (LVN 2 and 3), registered nurse 2 (RN 2) and certified nurse assistants 1 and 2 (CNA 1 and 2) had the specific competencies to care for one of one sampled resident (Resident 1) by not educating the nurses on the proper use of transfer poles (floor to ceiling grab bars used as a standing aid). This failure had the potential to result in staff misuse of the transfer pole and can lead to resident harm or injury. Findings: A review of the Resident 1s admission record (face sheet) indicated the facility admitted Resident 1 on 2/25/2022. Resident 1's diagnoses included cerebral infarction (disrupted blood flow in the brain leading to brain damage), muscle wasting (thinning) and atrophy (overall loss of muscle mass), type 2 diabetes (body cannot process glucose[blood sugar] properly), depression (mood disorder characterized by persistent sadness or loss of interest affecting daily life), cirrhosis of the liver (late stage of scarring (fibrosis) of the liver[organ in body helps digest food, store energy, and remove poisons]), liver transplant status (resident had her diseased liver replaced with a healthy liver), convulsions (general term for uncontrollable muscle contractions), and hemiplegia (paralysis of one side of the body). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/27/2022, the MDS indicated Resident 1 had severely impaired cognitive (ability to learn, remember, understand, and make decision) skills for daily decision making. Resident 1 needed limited assistance (resident highly involved in activity staff guided)with eating, and total dependence with bed mobility, transfer, toilet use, and personal hygiene. Resident 1 required one person's physical assistance with personal hygiene, bed mobility, eating, and toilet use. A review of Resident 1's order summary report for active orders as of 3/9/2022 indicated, as of 2/28/2022, a transfer pole had to be at the right side of Resident 1's bed. A review of Resident 1's care plan for status post fall indicated starting on 3/1/2022, a transfer pole had to be at the right side of Resident 1's bed. During a phone interview with the director of nursing (DON) on 3/14/2022 at 1:50 p.m. DON stated he was not sure if certified nurse assistants (CNA) were trained on how to use the transfer pole. Per DON, there was no policy on transfer pole use. During a phone interview with CNA 2 on 3/14/2022 at 2:00 p.m., CNA 2 stated she has been with the facility for twenty-eight years. Per CNA 2, she was not trained how to use the transfer poles at the bedside. (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	07/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with LVN 2 on 3/14/2022 at 2:30p.m., LVN 2 stated transfer poles were at the bedside for some residents in the facility. Per LVN 2, she knew how to use it but not properly. Per LVN 2, no training was ever done where she was required to do a return demonstration on properly using the transfer pole. During a phone interview with CNA 1 on 3/15/2022 at 8:10 a.m., CNA 1 stated that physical therapy taught her how to use the transfer pole years ago. Per CNA 1, no training was ever done where she was required to do a return demonstration and was signed off by trained personnel on properly using the transfer pole. During a phone interview with LVN 3 on 3/15/20022 at 8:18 a.m., LVN 3 stated no training was ever done where she completed a return demonstration on properly using the transfer pole. During a phone interview with RN 2 on 3/15/20022 at 8:19 a.m., RN 2 stated no training was ever done where she completed a return demonstration on properly using the transfer pole. During a phone interview on 3/15/2022 at 9:11 a.m., the Rehabilitation Director (RD) stated when working on a resident with any assistive device they educate the CNA at the bedside with a one-on-one education on proper use. Per RD, not all nurses have been educated on the proper use of the transfer pole with return demonstration to ensure competency for using transfer poles. Per RD, since all nursing staff had the accessibility to use the transfer poles, the facility needed to educate all nursing staff and to ensure competency with return demonstration on how to use transfer poles properly. A record review of the facility's facility assessment updated 3/10/2022 indicated DON conducted licensed nursing skills check and competencies upon hire, annually at the time of performance evaluation and as needed; and director of staff development (DSD) conducted CNA skills competencies upon hire, annually at the time of performance evaluations and as needed. Per facility assessment, licensed professional in the rehabilitative services (services to help residents return to daily life and live normal or near- normal way) can initiate a maintenance program which nursing or restorative aides will implement to assure residents maintain functional and physical state.