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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to protect the rights of the residents to be treated with dignity and respect and provide care in a manner that promotes the resident's quality of life for two of three sampled residents (Resident 9 and 66): a. by not thoroughly cleaning Resident 9 after a bowel movement. b. by not covering Resident 66's unclothed body to maintain privacy and dignity. These deficient practices had the potential to cause embarrassment, feelings of unworthiness and had a potential for more psychosocial harm to Resident's 9 and 66. Findings: a.A review of the admission record indicated Resident 9 was admitted on [DATE] with diagnoses of hypertension (high blood pressure), anemia (a condition where the body lacks the ability to carry adequate oxygen to the body tissues), acute respiratory failure, tracheostomy (surgically created hole that passes from the neck to the windpipe to allow direct access to breathing and airway) , dysphagia (difficulty swallowing food or liquids), and gastrostomy (a surgical opening in the abdominal wall of the stomach, used for liquid nutrition through plastic tubing). A review of the Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 8/4/2021, indicated Resident 9 was cognitively (ability to learn, remember, understand, and make decisions) intact. The MDS indicated Resident 9 was totally dependent on staff for bed mobility, transfer, toileting, eating, and personal hygiene. During an interview on 12/13/2021 at 12:23 a.m., Resident 9 and a family member (FM1), Resident 9 stated that a lot of times when she pressed the call light for help, certified nursing assistant (CNA) 4 just turned the call light off and walked away, Resident 9 stated that when CNA 4 turned the call light off and walked away, without asking her what she needed, it really affected her dignity and made her feel like she was less of a person. FM 1 stated that many times, she had to come to the facility at 03:00 a.m., 03:30 a.m., and 04:00 a. m., to change Resident 9's adult briefs, because it was soaked with urine and feces. (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	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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2021 at 3:15 p.m., Resident 9 stated that, there was a time at two O'clock in the morning when she called for help and nobody came to help her. Resident 9 stated she felt like she was wet, so she checked her adult briefs and pulled out a handful of feces. Resident 9 stated CNA 4 did not clean her nicely and she still had feces on her lower body. Resident 9 stated she had to call her daughter to come to the facility early in the morning to change her adult briefs and provide care for her. Resident 9 stated that it made her feel distressed, like she was nothing, it really affected her psychosocial being, her dignity and her whole being. b.A review of the admission record indicated Resident 66 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (when a lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), dysphagia (difficulty swallowing), dependence on ventilator (dependent upon mechanical life support because of inability to breathe effectively), unspecified convulsion (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). A review of the MDS, dated [DATE], indicated Resident 66 had severe cognitive impairment. During an observation on 12/13/2021 from 11:39 a.m., until 11: 52 a.m., Resident 66 was laying on the bed, exposed and visible to passersby with only adult briefs on. During an interview on 12/14/2021 at 3:31 p.m., Resident 66's family member (FM) stated that the facility did not cover Resident 66's body and exposed her, to staff, vendors, and other residents' family members. FM stated that if she herself was left exposed for periods of time, that would really affect her whole being negatively, FM stated it really was a dignity issue. During an interview on 12/17/2021 at 12:03 p.m., CNA 12 acknowledged that leaving any resident exposed with no privacy is a dignity issue, that would make someone so uncomfortable. CNA 12 stated it was important to make sure Residents of the facility were treated with dignity. During an interview on 12/17/2021 at 12:06 p.m., CNA 13 stated that having someone seeing your private parts exposed not only to the staff but other residents and family members, was a bad feeling and very uncomfortable. That will really make you less of a human being. That's very clearly a dignity issue. During a review of the facility's P/P titled, Dignity dated revised February 2021, the P/P indicated: each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. When assisting with care, residents are supported in exercising their rights. For example: residents are encouraged to dress in clothing that they prefer: Staff promote. maintain and protect resident privacy. including bodily privacy during assistance with personal care and during treatment procedures.

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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42380 Based on observation, interview, and record review, the facility failed to ensure one of 27 sampled residents (Resident 13) was treated with respect and dignity by not returning the resident's belongings when the resident requested for them after being readmitted back into the facility. This deficient practice caused Resident 13 to have decreased feelings of self-worth and quality of life, resulting in Resident 13 not wanting to get out of bed. Findings: A review of the admission record (Facesheet) indicated Resident 13 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses not limited to heart failure (a condition in which the heart has trouble pumping blood thought the body), muscle weakness, type 2 diabetes (abnormal blood sugar), atrial fibrillation (rapid, irregular beating of the heart), and chronic kidney disease (kidneys are damaged and can get worse over time when not filtering blood the way they should). A review of the Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 11/8/21, indicated Resident 13's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident had no cognitive impairment; required extensive assistance from staff with bed mobility, dressing, toileting, and total dependence from staff with bathing; and used a wheelchair as a mobility device. During an observation and interview on 12/16/21, at 9:22 a.m. with Resident 13, the resident's room was observed in the green zone (area for residents who are not exposed and have tested negative for COVID-19 [a highly contagious infection, caused by a virus that can easily spread from person to person]). The resident stated he was in the hospital from 11/30/21 to 12/8/21. Resident 13 stated he needed his shoes, glasses, and power chair. Resident 13 stated he feels uncomfortable without his belongings and that he needed his glasses to see because he has impaired vision. The resident stated he has the right to have his belongings and requested his belongings from Social Services Director (SS) but was told by SS that he would get his belongings back after he was out of quarantine. During a follow-up interview on 12/14/21, 4:05 p.m. with Resident 13, the resident stated, I don't get around. I sit in bed all day and night. I don't have my shoes, no house shoes. It makes me feel useless. I don't feel right. During an interview on 12/16/21, at 9:04 a.m. with Certified Nursing Assistant (CNA 17), the CNA stated Resident 13 has been staying in the bed and hasn't been getting up. CNA 17 stated the resident used to get up out of bed and use his powerchair. During a follow-up interview on 12/17/21, at 10:23 a.m. with CNA 17, the CNA stated she took care of Resident 13 last week and he told her he wanted his clothes back. CNA 17 stated she did not tell anyone. (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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/20/21, at 10:49 a.m. with CNA 10, the CNA stated Resident 13 had a doctor's appointment today at 10:30 a.m., and wanted to wear his personal clothing, not the facility's gown. CNA 10 stated he was frustrated and irritated and refused to go to the appointment. CNA 10 stated she told the social worker he needed his clothes, but he was already mad after he received them. CNA 10 stated the resident told her he wanted his clothes and dentures and did not want to go back to the other room. CNA 10 stated if he did not have his personal belongings it would affect his quality of life, resulting in resident not wanting to go out of his room. During an interview on 12/14/21, at 3:29 p.m. with SS, the SS stated when residents are admitted into the hospital, their belongings will be held in storage until the resident returns, and they are supposed to get their items back. During an observation and interview on 12/14/21, at 3:54 p.m. with SS, observed storage shed in parking lot. SS used key to unlock door and observed three bags of belonging and one power chair for Resident 13. SS stated Resident 13 was readmitted to a different room and will get his items back once he returns to his old room. SS stated Resident 13 only requested for his cell phone and money and did not request for other items. SS stated Resident 13's old room is currently occupied and was not sure how long it would be occupied for. SS stated Resident 13 was on quarantine until returning to old room and had requested to go back to his room. During a follow-up interview on 12/17/21, at 10:18 a.m. with SS, the SS stated Resident 13's belongings are still in storage because his current room cannot accommodate his belongs because he has too much stuff. SS stated the other room is more spacious and will do a room change for the resident next week. SS stated Resident 13 did not request for anything else. During an interview on 12/17/21, at 10:40 a.m. with Director of Nursing (DON), the DON stated when a resident goes to the hospital, their belongings go to storage. DON stated Resident 13 had a lot of items but has the right to accommodate a few of those items in his current room, because he owns it. DON stated if resident expresses to CNA he wants his belongings, the expectation is for nursing or social services staff to address it. DON stated when Resident 13 was readmitted to the facility he did not mention he wanted his belongings. DON stated his power chair could be accommodated in his current room. DON stated Resident 13 has used the power chair since he was admitted into the facility and it is his mode of transportation. A review of the facility's policy, Resident Rights, revised 12/2016, indicated federal and state laws guarantee certain basic rights to all residents of this facility including the right to retain and use personal possessions to the maximum extent that space and safety permit. A review of the facility's policy, Dignity, revised 2/2021, indicated residents' private space and property are respected at all times. Staff do not handle or move a resident's personal belongings without the resident's permission.

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the nursing staff failed to ensure bed control and call light devices were within reach for one of three sampled residents (Resident 74). This deficient practice had the potential for the facility not to address Resident 74's induvial hydration, medical, elimination and comfort needs. Findings: A review of Resident 74's Face Sheet (admission record) indicated Resident 74 was admitted to the facility on [DATE]. Resident 74's diagnoses included encephalopathy (term for any brain disease that alters brain function or structure), abnormalities of gait and mobility, epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) and essential hypertension (high blood pressure). During a review of Resident 74's Minimum Data Set (MDS-a comprehensive assessment and care planning tool) dated 07/06/2021 indicated Resident 74 had impaired cognitive function (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required limited assistance for bed mobility and transfer and required extensive assistance for getting dressed, toilet use and personal hygiene. During a review of Resident 74's Care Plan (CP) dated, 06/08/2021, indicated, Resident 74 had ADL (activities of daily living) self-care performance deficit related to history of cardiovascular accident ([CVA] stroke) and seizure and resident required assistance by one staff to turn and reposition in bed and transfer and needed to use call bell for assistance. During an observation on 12/13/2021 at 10:11 a.m., Resident 74's bed control was on the floor and the call light was at the bottom of the head of bed. During an observation on 12/15/2021 at 09:32 a.m., Resident 74's bed control and call light were hanging on the floor. During an interview on 12/15/2021 at 09:35 a.m., certified nursing assistant (CNA 1) acknowledged that when a resident cannot reach the call light, there's a potential for falls and resident would be at high risk for injury. CNA 1 stated if the resident could not reach the call light and could not call for help, it did not accommodate the residents' needs and it would make the resident feel like less of a person, which could lead to depression, anxiety, restlessness because the resident did not have the control to ask for help. During an interview on 12/17/2021 at 12:01 p.m., licensed vocational nurse (LVN 2) confirmed that if a resident could not reach the call light, it was just too impossible to call for help and that could drive one crazy when one is not able to get help and when a resident really needed help and help did not come, it would affect ones psychosocial being and the resident might get up and fall if the resident cannot wait for the help needed. (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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P/P) titled, Accommodation of Needs dated revised January 2020, indicated: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being.

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

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 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. 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. (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

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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

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 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)

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

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 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)

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

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 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.

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

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 42243 Based on interview and record review, the facility failed to ensure resident's mail were delivered unopened and on Saturdays for two of 13 residents (Residents 59 and 88) as stated during the resident council. These deficient practices resulted in the feeling of lack of privacy and untimely delivery of mail for Residents 59 and 88. Findings: During the resident council meeting, on 12/14/21, at 10:46 a.m., Resident 59 stated sometimes her mail is opened and she does not always get mail right away. Resident 59 stated the staff wait for there to be more mail for individual residents before delivering. Resident 88 stated she had two pieces of mail opened before and gets mail on weekends sometimes. During an interview on 12/22/21, at 9:36 a.m., with Activities Director (AD), the AD stated mail is delivered to the business office daily. AD stated she distributed mail to alert residents and sent mail for non-alert residents to their family or conservators. AD stated there were days when mail delivery to residents got skipped because the mail arrived late in the day and the activities department were gone for the day. AD stated sometimes residents received more mail because they received two days' worth of mail. AD stated on the weekends she assigned an assistant to check and distribute the mail. AD stated mail should be delivered in good condition, closed, sealed, and not damaged. During an interview on 12/22/21, at 9:43 a.m. with Business Office Manager (BOM), the BOM stated her shift was from 8:30 a.m. to 5:00 p.m. on weekdays. BOM stated she sorted the mail and set residents' mail aside. BOM stated activities assistants usually collected the mail from her if they were working. BOM stated when she is not working, activities had access to her office to retrieve mail. BOM stated she saw mail left over from the weekend and realized activities did not distribute mail on the weekends. During a review of the facility's policy titled, Resident Rights, revised 12/2016, indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to have access to a telephone, mail, and email.

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on interview, and record review, the facility failed to provide 24 out of 27 sampled residents (323, 6, 3, 57, 173, 74, 11, 71, 4, 22, 42, 9, 66, 109, 419, 86, 96, 85, 420, 169, 23, 170, 102, and 171), and or their responsible parties, with written information on how to formulate an Advanced Directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor). This deficient practice had the potential for violating Resident 323, 6, 3, 57, 173, 74, 11, 71, 4, 22, 42, 9, 66, 109, 419, 86, 96, 85, 420, 169, 23, 170, 102, and 171 choices about their medical care. Findings: During a review of Resident's medical records, the following information was missing: -Resident 323 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 6 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 3 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 57 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 173 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 74 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 11 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 71 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 4 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. (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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident 22 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 42 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 9 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 66 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 109 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 419 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 86 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 96 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 85 (admitted on [DATE] and readmitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 420 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 169 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 23 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 170 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 102 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. -Resident 171 (admitted on [DATE]) did not have an advanced directive or a signature declining information on how to obtain an advanced directive. (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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/14/2021 at 3:43 p.m., the Social Services Director (SSD) stated that advance directives must be in the resident's chart within 4 days upon admission, if the resident had an advance directive before admission, the facility would just obtain a copy, if the resident needs a witness then the facility can help accommodate witnessing for advance directives form. During an interview on 12/15/2021 at 4:12 p.m., the SSD assistant stated that advance directives must be in the chart upon admission. If the resident does not have an advance directive, it should be in the Social Services notes, if the resident does not want to execute one During an interview and concurrent record review (RR) on 12/22/2021 at 08:51 a.m., the SSD assistant stated that advance directive must be in the chart as soon as possible, there must be a form that it was offered, and it should be in the resident's chart, if not it must be documented in the Social Services notes. RR with SSD assistant indicated, there was no advance directives forms to all the mentioned residents' above and RR indicated, there was no documentation in the Social Services notes. During a review of the facility's policy titled, Advance Directives dated revised December 20, the P/P indicated: Advance directives will be respected in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist and the president's decision to accept or decline assistance.

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

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44161 Based on observation, interview and record review, the facility failed to ensure residents know how to file their grievances (official statement of complaints) for four of 13 residents (Residents 10, 21, 24 and 49) who attended the resident council (a monthly gathering of residents independent of the facility to discuss concerns about quality of care, and quality of life) meeting. This deficient practice violated the resident's right to have their grievances addressed. Findings: During a group interview at the resident council meeting on 12/14/21, at 10:35 am, Resident 10, 21, 24 and 49 stated that they do not know how to file a grievance. During an interview on 12/22/2021, at 9:56 am with Social Services Director (SS), the SS stated residents are reminded and encouraged during admission and quarterly assessment on how to file grievances. SSD stated the process to file a grievance is to notify the social services department and fill out a grievances form. SS stated an investigation starts once an issue is made. SS stated that during the weekends, residents can bring up their issues to the nurses and grievances can be communicated to social services department on the following Monday. SS stated resolution time of the grievance varies. During a review of the facility's policy, Resident Rights, revised 12/2016, indicated resident has the right to voice grievances to the facility, or other agencies without discrimination or fear of reprisal.

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

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 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)

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

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 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)

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

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 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)

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

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 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.

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

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 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

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 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)

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

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 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.

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to ensure one of three residents' (Resident 22) head of the bed was elevated to 30 to 45 degrees during administration of medications and enteral feeding (a form of nutrition that is delivered directly into the gastrointestinal system using a flexible tube inserted through the nose or abdominal wall) thru a gastrostomy tube (GT- is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications This deficient practice placed Resident 22 at risk for aspiration (accidental breathing in of food or fluid into lungs which can cause serious lung problems). Findings: During a medication pass observation on 12/15/21, at 8:47 am, Licensed Vocational Nurse 3 (LVN 3) administered medication via gastrostomy tube while Resident 22 bed was on a flat position and receiving enteral feeding. During an interview on 12/16/21, at 10:53 am with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated that residents should be in a 45 degrees position when medicines are administered thru gastrostomy tube to prevent aspiration. During a record review of Resident 22's Admission Record on 12/28/21, Resident 22 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure ((condition in where your lungs can not get enough oxygen into the blood), hemiplegia (paralysis of one side of the body), dysphagia (difficulty in swallowing caused by nerve or muscle problems), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), tracheostomy (an opening surgically created through the neck into the windpipe(trachea) to allow direct access to the breathing tube) and dependence on ventilator status (inability to breathe without the assistance of mechanical ventilator (a machine that takes over the work of breathing when a person is unable to breathe on his own). During a record review of physician's order dated 9/23/2018 , indicated an active physician's order to elevate head of the bed 30 degrees to 45 degrees during feeding. During a record review of policy and procedure titled, Enteral Feeding, revised in September 2018, indicated that residents receiving enteral feeding will be in a position where the head of the bed is at 30 degrees to 45 degrees for feeding. During a record review of an online article in a Nursing Journal title Nursing 2022, dated September 2011, indicated that the current recommendation is that all patients receiving enteral nutrition must have the backrest elevated to a minimum of 30 degrees and preferably to 45 degrees. (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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of [NAME] Procedures regarding Enteral tube feeding, (a method of delivering nutrients directly into the gastrointestinal tract), revised November 2021, indicated that patients receiving enteral nutrition will be positioned with the head of the bed at least 30 degrees or position the patient upright in a chair.

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44161 Based on observation, interview, and record review, the facility failed to: a.Provide supervision to one of five known residents who wander (Resident 83) from entering Resident 106's room. This deficient practice resulted in Resident 106 getting angry that Resident 106 violated his personal space and privacy. b. Provide safety to all facility's staff and residents by monitoring opened doors after paramedics left facility. This deficient practice had a potential for residents to leave the facility, with no one knowing their whereabouts, getting lost, getting hurt, and had the protentional for unauthorized persons entering the facility, placing the residents and staff of the facility at risk. Findings: a. During an observation on 12/13/21, at 12:28 p.m., surveyor overheard Resident 106 yelling loudly, Get the f&%k out of here. Surveyor observed Resident 83 who was in a wheelchair, wheel himself into Resident 106's room. Certified Nursing Assistant (CNA 19) took Resident 83 back to his room. A review of Resident 83's admission record, indicated the resident was admitted to the facility on [DATE], with diagnoses not limited to heart failure (a condition in which the heart has trouble pumping blood thought the body), dementia (memory loss) with behavior disturbance, end stage renal disease ([ESRD] the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) and 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). A review of Resident 83's Minimum Data Set ([MDS] a standardized assessment and screening tool) dated 10/7/21, indicated the resident had severe cognitive impairments; required extensive assistance from staff for bed mobility, locomotion on/off unit, dressing, toileting; and total assistance from staff with bathing. During an interview on 12/14/21, at 8:21 a.m. with Resident 106, the resident stated yesterday resident 83 came into his room. Resident 106 stated Resident 83 has been in his room before and tried to take his belongings. During an observation on 12/13/21, at 3:48 p.m., Resident 83 was in his wheelchair and placed his hand on room [ROOM NUMBER]'s doorknob and attempted to open. Observed staff wheelchair the resident back to his room. During an observation and interview on 12/14/21, at 2:17 p.m., Resident 83 had wander guard (device that will transmit alarm when resident attempts to leave the facility) on his left wrist, sitting in the hallway with CNA 18, CNA 19, and Assistant Staff Developer (ASD). ASD stated Resident 83 is a wanderer. CNA 19 stated Resident 83 usually goes around the hallway in his wheelchair. (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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/21, at 2:24 p.m. with CNA 19, the CNA stated Resident 83 tends to get into the rooms a lot causing other residents to get mad and upset. The CNA stated Resident 83 wanders every day. CNA 19 stated staff assigned to him oversees monitoring him, but all staff knows his behavior and is watching him. CNA 19 stated yesterday when passing lunch trays, she saw Resident 83 go into Resident 106's room. CNA 19 stated Resident 106 was mad and was yelling. During an interview on 12/14/21, at 2:30 p.m., with Licensed Vocational Nurse (LVN 14), the LVN indicated Resident 83 goes around the facility in his wheelchair and sometimes goes to other residents' rooms. LVN 14 stated interventions to address his behavior are to use a wander guard, redirect him, provide constant reminders of where his room is, and having him participate in activities for distraction. LVN 14 stated CNAs know his behavior and will take him back to his room if he is wandering. During an interview on 12/14/21, at 2:37 p.m. with Registered Nurse Supervisor (RN 5), the RN stated residents are assessed for wandering upon admission and to update the care plan for behavior with interventions including the use of a wander guard, have residents participate in activities, have staff keep close on the resident and endorse shift to shift. RN 5 stated most of the CNAs know which residents have a habit of wandering. RN 5 stated it important to keep an eye on residents who wander to not lose them from entering other resident rooms, causing other residents to get upset. During an interview on 12/14/21, at 2:46 p.m. with Director of Nursing (DON), the DON stated wander assessment is part of admission assessment. If wandering is a triggered in the admission, it will be documented and to the doctor and family are notified, and wandering behavior is care planned for. DON stated interventions for resident who wander are to use wander guard, provide constant or adequate supervision by all staff through visual checks. A review of physician orders indicated Resident 83 had order wanderguard for elopement risk every shift starting 8/16/21. A review of Change of Condition form dated 8/16/21, indicated Resident 83 had wandering behavior, attempting to go out of the facility. A review of Resident 83's care plans did not indicate wandering behavior was care planned for. A review of the facility's policy, Wandering and Elopements, revised 3/2019, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintain the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. b. During an observation on 12/17/21, at 5:58 a.m., observed two side doors facing the street wide opened, no gates surrounding the opened doors. Observed ambulance leaving facility. During an observation on 12/17/21, at 5:59 a.m., observed RN 6 glance at the side doors and used the restroom facing the doors. During an observation on 12/17/21, at 6:16 a.m., Admin arrived through the side doors and shut the doors. (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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/21, at 6:50 a.m. with RN 6, the RN stated when paramedics are leaving the facility, staff should usually escort them out and close the door. RN 6 stated it is important to close the doors immediately to prevent residents from going outside without being noticed, especially for residents that wander. RN 6 stated it is important to close the doors to prevent people from outside to enter the facility. RN 6 stated when she used the restroom in the morning, she did not notice the front doors were still open. During an interview on 12/17/21, at 6:16 a.m. with Admin, when asked what could happen if the doors were left open, Admin stated it would not be a problem for residents that wander because their bracelet will trigger the alarm when they pass the doors. Admin stated it could be a problem for those that are not a wanderer and will educate staff to close doors if left opened.

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42380 Based on observation, interview, and record review, the facility failed to prevent dehydration for one (1) out of eight (8) sampled resident (Resident 62) by failing to: 1. Monitor and address Resident 62's symptom of dehydration (elevated sodium) 2. Ensure Resident 62 received adequate hydration to maintain well being 3. Develop an individualized/person centered care plan with goals and interventions for dehydration. This deficient practice resulted in Resident 62's risk for dehydration, and hospitalization . Findings: During a review of Resident 62's Admission Face Sheet, the Face Sheet indicated Resident 62 was originally admitted to the facility on [DATE] and recently readmitted [DATE]. Resident 62's diagnoses included respiratory failure (inadequate gas exchange), pneumonitis due to inhalation of food and vomit (inflammation of lung tissue), dementia (disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning), Parkinson's disease (a progressive disease of the nervous system resulting in impaired movement), Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks), and diabetes mellitus (high blood sugar). During a review of Resident 62's Minimum Data Set (MDS), a comprehensive assessment and care screening tool, dated [DATE], the MDS indicated Resident 62's cognitive (mental action or process of acquiring knowledge and understanding) function is severely impaired and always incontinent (inability to control) of bladder and bowel. The MDS indicated Resident 62 was totally dependent with a one to two-person physical assist for bed mobility, transfer, dressing, toilet use and personal hygiene. Resident 62 require extensive assistance with one-person physical assist for eating. During a review of Resident 114's Admission Face Sheet, the Face Sheet indicated Resident 114 was originally admitted to the facility on [DATE] and recently admitted [DATE]. Resident 114's diagnoses included paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord or nerve problems) and major depressive disorder (mood disorder that causes persistent feelings of sadness and loss of interest and can interfere with your daily functioning). During a review of Resident 114's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 114's cognitive function was intact with the capacity to understand and make decisions. The MDS indicated Resident 114 required extensive assistance with one person assist for bed mobility and getting dressed. She required limited assistance with one person assist for toilet use and personal hygiene. Resident 62 required supervision with one-person physical assist for eating. (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.During a concurrent observation and interview on [DATE] at 12:19 p.m., Resident 62 was observed lying in bed sleeping. Resident 114 stated that Resident 62 was usually awake, but she has been sleeping more and more and eating less the past three (3) days. Resident 114 stated that Resident 62 need help with eating and drinking. She stated that she heard staff saying that Resident 62's diaper has been dry. During a concurrent observation and interview on [DATE] at 7:22 a.m., Code blue (a medical emergency in which a team of medical personnel work to revive an individual when the heart stops) was called over head for Resident 62. Staff present included Registered Nurse (RN3), Licensed Vocational Nurse (LVN 8) and Respiratory Therapist (RT1). Director of Nursing (DON) stated that Resident 62 was desaturating (level of oxygen in the body is low) and residents' eyes are closed but with body movement. During observation on [DATE] at 7:30 a.m., 911 arrived at the facility. During observation on [DATE] at 7:38 a.m., 911 left facility with Resident 62 During an interview on [DATE] at 7:45 a.m., Resident 114 stated that Resident 62 was sleeping all night and was awake in the morning but did not eat breakfast. Resident 114 stated that Resident 62 have not been eating for about two to three days. She stated that around 5:30 p.m. yesterday Resident 62 vomited during dinner after staff gave her ensure supplement to drink. She stated that Resident 62 would sometimes tell staff no pee pee. During an interview on [DATE] at 7:47 p.m., LVN 8 stated that Resident 62 was found short of breath during rounds today and not responding. She stated vitals were taken and found resident's oxygen saturation ([O2 sat] measure of amount of oxygen traveling through the body with your red blood cells with normal level range between 95% - 100%) at 85% room air; 5 liters per minute (LPM) of oxygen via nasal canula (devise used to deliver supplemental oxygen or increased airflow) was placed on Resident 62 and O2 sat went up to 95%. During review of 'Progress Notes' dated [DATE] timed at 7:20 a.m., indicated that paramedics arrived and assessed resident at bedside with O2 sat 95% at 5LPM via nasal canula, resident awake and alert to name, HOB (head of bed) maintained elevated, BP ,d+[DATE] ([BP - Blood pressure - force of blood pushing against the walls of your arteries with normal pressure below 120 mm Hg systolic and 80 mm Hg diastolic), pulse ,d+[DATE] (fluctuates) no c/o pain or discomfort, resident assisted by paramedics to gurney and transferred the resident to an acute care facility for eval and left at 7:40. During review of 'Progress Notes' dated [DATE] at 6:00 p.m., indicated resident was readmitted from acute care x 1 nonverbal with O2 sat at 2LPM via N/C no facial grimacing or pain, transported via ambulance .with new order for Hospice (plan of comfort care with focus on quality of life with compassion and dignity for end-of-life care) Evaluation . (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of 'Progress Notes' dated [DATE] time at 3:39 a.m., indicated upon rounds @ approx. 2300 (11:00 p.m.) writer ([License Vocational Nurse] - LVN10) noted resident lying on bed without distress noted, chest noted with rise and fall, respirations present, pulse palpable, resident warm to touch, @ approx. 0030 (12:30 a.m.) CNA came to writer to inform that resident seemed listless or non-responsive, writer noted resident with no respirations, pulse non-palpable, resident is DNR (no not resuscitate - medical written order by a physician that instructs health care providers not to do cardiopulmonary resuscitation), writer informed RN supervisor. During review of 'Progress Notes' dated [DATE] time at 12:33 a.m., indicated resident found pulseless, no palpable B/P (blood pressure), resident DNR called Doc1's exchange. Spoke with exchange regarding resident passing. Called husband made aware, also called [NAME] Hills mortuary per husband wishes. Obtained T/O (telephone order) for D/C (discharge) body to [NAME] Hills Mortuary. During review of facility's 'Record of Death,' undated, indicated that Resident 62's date of death was [DATE] and time of death was 12:33 a.m. During observation and interview on [DATE] at 3:20 p.m., Resident 114 was observed crying in her room because she is very upset about Resident 62's passing. She stated Resident 62 was not eating or drinking for about 5 days and the staff don't try to feed or give her water. Resident 114 stated staff leave the tray at Resident 62's bedside and call her name, but if she doesn't respond they don't try to feed or give her fluids. She stated no water randomly offered to Resident 62 throughout the day, only with meals if staff is willing to sit and help her. Resident 114 stated there have been times that she helps Resident 62 because she can't do it herself. During review of 'Progress Notes' dated [DATE] timed at 9:20 a.m., indicated that doctor (Doc1) ordered Atarax 10mg PO TID x5 for skin irritation to upper chest area. During review of 'Progress Notes' dated [DATE] timed at 10:46 p.m., indicated resident is monitoring for itching. Resident noted with dry skin and minimal redness. During review of Resident 62's 'Lab Results Report' dated/collected [DATE], indicated labs are as follows: Sodium ([Na+] electrolyte that helps regulate the amount of water that is in and around cells with normal range ,d+[DATE] meq/L (milliequivalents per liter - amount of a substance that will react with a certain number of hydrogen ions) Estimated Glomerular Filtration Rate (eGFR - measures kidney's ability to filter toxins or waste from your blood). Normal range ,d+[DATE]mg/dl (milligram per deciliter - unit of measure that show the concentration of a substance in a specific amount of fluid) Blood Urine Nitrogen (BUN - medical test that measure amount of urea nitrogen found in blood with normal range ,d+[DATE]mg/dl) Creatinine (measure of how well your kidneys are performing thier job of filtering waste from your blood with normal range 0.60 - 1.20 mg/dl) Sodium 152 Meq/L () (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eGFR 34 (normal range >/= 60) BUN 27 mg/dL (normal range ,d+[DATE]mg/dl) Creatinine - 1.48 mg/dL (normal range 0.60 - 1.20 During review of Resident 62's 'Lab Results Report' dated/collected [DATE], indicated labs are as follows: Sodium (Na+) 146 Meq/L (normal range ,d+[DATE]meq/L) eGFR 43 (normal range >/= 60) BUN 28 mg/dL (normal range ,d+[DATE]mg/dl Creatinine - 1.19 mg/dL (normal range 0.60 - 1.20 mg/dl) During review of Resident 62's 'Lab Results Report' dated/collected [DATE], indicated labs are as follows: Sodium (Na+) 147 Meq/L (normal range ,d+[DATE]meq/L) eGFR 44 (normal range >/= 60) BUN 28 mg/dL (normal range ,d+[DATE]mg/dl Creatinine - 1.18 mg/dL (normal range 0.60 - 1.20 mg/dl) Notes indicated that Doc1 was made aware A review of Resident 62's acute hospital's Emergency Department documents dated [DATE] at 4:39 p.m., indicated that assessment shows severe dehydration and malnutrition, renal failure, NSTEMI, Alzheimer, COPD, Parkinson and hypertension. During review of Resident 62's labs collected from acute hospital dated/collected [DATE] at 8:07 a.m., indicated labs are as follows: Sodium (Na+) 176 Meq/L (normal range ,d+[DATE]meq/L) eGFR 13 (normal range >/= 60) BUN 71 mg/dL (normal range ,d+[DATE]mg/dl Creatinine - 3.4 mg/dL (normal range 0.60 - 1.20 mg/dl) (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on [DATE] at 3:55 p.m., Dietary Consultant (DC) stated that she looks at the resident's fluid intakes and labs such as sodium, BUN and creatinine to determine hydration. DC stated it looks like the last time Resident 62 had labs drawn were on [DATE] which indicates that resident's sodium level of 147 and Bun of 28 are elevated from the normal range. She stated that she did not see those labs, but if she did, she would repeat and monitor Resident 62's labs, consult with a physician to consider intravenous fluids ([IVF] specifically formulated liquids that are injected into a vein to prevent or treat dehydration), continue to follow up and monitor repeated labs. DC stated that Resident 62's lab report from the hospital indicates that she is dehydrated and is very alarming. She stated that if labs were monitored more closely, the dehydration could possibly have been avoided. She stated that she is upset with herself that she missed reviewing the [DATE] labs. During interview on [DATE] at 8:28 a.m., RN3 stated Resident 62's oxygen saturation was in the 80s, residents head was elevated, placed 2-liter oxygen via nasal canula per standing order. She stated Resident 62's baseline is nonverbal but awake. She stated resident was sent to acute hospital on [DATE] but returned on the same day with hospice evaluation order. She stated sodium level of 176 is high and shows Resident 62 is dehydrated and it can cause death. During interview and record review on [DATE] at 1:20 p.m., Licensed Vocational Nurse (LVN13) stated the Resident 62 is bed ridden, confused, need assistance with feeding, drinking, toileting, turning and ADLs (activities of daily living). She stated that when lab results are received, she would compare them from previous labs and notify the physician of any out-of-range labs. LVN13 stated that sodium 147 Meq/L is elevated and BUN 28 is reportable and if both elevated, intravenous fluids are usually ordered. She stated there is no charting in the progress notes that indicates the labs collected on [DATE] were addressed but faxed to hematologist. During interview on ,d+[DATE].2021 at 2:38 p.m., Director of Nursing (DON) stated lab faxes the facility results and Registered Nurse supervisors or charge nurse will either call doctor or fax labs to specialist. He stated Resident 62 is high risk for dehydration and sign and symptoms he looks for includes dry skin, sunken face, drowsiness, urine output and labs. DON stated that Atarax was prescribed to Resident 62 for dry skin but is not sure if dry skin is due to dehydration because it could be anything. DON stated he does not know how Resident 62's sodium level was elevated to 176 meq/L at the hospital. He stated dehydration can happen quickly. 2. During review of Resident 62's December fluid intake are as follows: [DATE] 1:19 p.m. - 360 ml 1:19 p.m. - 360 ml 10:19 p.m. - 400 ml [DATE] 1:29 p.m. - 360 ml (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:29 p.m. - 360 ml 9:47 p.m. - 400 ml [DATE] 4:40 p.m. - 240 ml [DATE] 6:04 p.m. - 240 ml [DATE] 7:30 a.m. - 240 ml 12:00 p.m. - 240 ml 4:45 p.m. - 240 ml [DATE] 9:48 a.m. - 240 ml 1:51 p.m. - 240 ml 9:02 p.m. - 240 ml [DATE] 1:53 p.m. - 360 ml 1:53 p.m. - 360 ml 9:22 p.m. - 400 ml [DATE] 5:00 p.m. - 240 ml [DATE] 2:14 p.m. - 360 ml 2:14 p.m. - 360 ml 4:36 p.m. - 240 ml (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 9:32 p.m. - 240 ml [DATE] 1:28 p.m. - 360 ml 1:28 p.m. - 360 ml 10:22 p.m. - 120 ml [DATE] 9:11 p.m. - 240 ml [DATE] 2:11p.m. - 120 ml 2:12 p.m. - 240 ml 9:26 p.m. - 0 ml [DATE] Resident not available [DATE] 10:25 p.m. - 400 ml During review of 'Bladder Continence Documentation Survey Report' in the month of December indicates the following output: [DATE] 2:52 a.m. x 1 4:43 p.m. x 1 [DATE] 1:57 a.m. x 1 10:24 p.m. x 1 1:29 p.m. x 1 (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 2:09 a.m. x 1 4:49 p.m. x 1 [DATE] 2:28 a.m. x 1 4:42 a.m. x 1 2:14 p.m. x 1 [DATE] 5:40 a.m. x 1 [DATE] 5:14 a.m. x 1 10:26 p.m. x 1 During review of facility's 'Nutritional Assessment' dated [DATE], indicated that identification of risk indicators included current food and fluid intake of ,d+[DATE]% with estimated fluid needs range of 1511 -1813 ml (, d+[DATE]ml/kg). During an interview and record review on [DATE] at 3:55 p.m., Dietary Consultant (DC) stated that according to the fluid intake recorded, Resident 62 was not getting enough water or fluids. She stated on [DATE], [DATE], [DATE], [DATE], [DATE] shows that Resident 62 only consumed 240 milliliters (ml - unit of volume in the metric system). DC stated in the month of December only [DATE], [DATE] and [DATE] indicates that Resident 62 received sufficient fluid. She stated that according to the amount of fluid intake charted correlates with the labs results found in the hospital. DC stated it's important to receive proper hydration because dehydration can cause death. During interview and record review on [DATE] at 1:20 p.m., Licensed Vocational Nurse (LVN13) stated the Resident 62 is bed ridden, confused, need assistance with feeding, drinking, toileting, turning and ADLs (activities of daily living). Fluids are typically given during mealtimes and medication pass, but resident is not capable of asking for hydration. LVN 13 stated they make sure residents are voiding and look at the color of urine. She stated that if residents don't void for 8 hours, she would let the physician know. (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and record review on ,d+[DATE].2021 at 2:38 p.m., Director of Nursing (DON) stated Resident 62 is alert, confused, slow feeder and needs help eating and drinking. He stated Resident 62 is high risk for dehydration and sign and symptoms he looks for includes dry skin, sunken face, drowsiness, urine output and labs. DON stated he does not know if Resident 62 was getting enough fluid daily. He stated he did not know how much fluid Resident 62 required before or after her hospitalization . DON could not verbalize when a physician should be alerted regarding hydration issues. 3. During an interview on [DATE] at 3:55 p.m., Dietary Consultant (DC) stated that she ordered extra 8 ounces of water with meals back in September for the resident 62, but no care plan was initiated for dehydration. She stated that the extra fluid was placed in the weight loss care plan, but there should be one specific for dehydration. DC stated that care plan is important to keep everyone informed of residents' plan of care with goals and measurable outcomes. During an interview on [DATE] at 2:38 p.m., Director of Nursing (DON) stated there is no care plan for dehydration. DON could not verbalize whether a dehydration care plan is imperative in Resident 62's care. Facility could not provide a dehydration care plan for Resident 62. A review of facility's policy and procedure (P&P) titled 'Monitoring and Follow-Up' revised ,d+[DATE], indicate 'the physician and staff will monitor for the subsequent development, progression, or resolution of fluid and electrolyte imbalance in at risk individuals. a. For example, replacement may be adequate if the resident is clinically stable, not having delirium, voiding at lease every ,d+[DATE] hours, and the urine specific gravity (where attainable) is less than 1.015. The physician will adjust treatments based on specific information (lab results, level of consciousness, etc.) relevant to that individual .b. Repeating the basic metabolic profile and/or serum osmolality can help track progress in correcting abnormalities. A review of facility's policy and procedure (P&P) titled 'Hydration' revised ,d+[DATE], indicate that the physician and staff will help define the individual's current hydration status (fluid and electrolyte balance or imbalances). The physician will distinguish various types of fluid and electrolyte imbalance (for example hyponatremia, hypernatremia, pre-renal azotemia, etc) from true dehydration (clinically significant loss of total body water) .The staff, with physician's input, will identify and report to the physician individuals with signs and symptoms (for example, delirium, lethargy, increased thirst, etc) or lab test results (for example hypernatremia. Azotemia, etc) that might reflect existing fluid and electrolyte imbalance .The physician will manage significant fluid and electrolyte imbalance, and associated risk, appropriately and in a timely manner. Timeliness depends on the severity, nature, and causes of the fluid and electrolyte imbalance .The staff shall provide supportive measures such as supplemental fluids and adjusting environmental temperature, where indicated. (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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) titled 'Change in a Resident's Condition or Status,' revised , d+[DATE], indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); impacts more than on area of the resident's health status; requires interdisciplinary review and/or revision to the care plan . A review of the facility's policy and procedure titled, Care plans, Comprehensive person-centered, revised , d+[DATE], indicated that a comprehensive, person-centered care plan will that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; .incorporate identified problem areas; incorporate risk factors associated with identified problems .The comprehensive, person centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). Assessments of residents are ongoing and care plans are revised a information about the residents and the residents' conditions change.

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

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42380 Based on observation, interview, and record review the facility failed to complete an assessment post-hemodialysis ([HD] - process of removing waste, salt, and extra water to prevent build up in the body for residents who had impaired kidney function) for one (1) of eight (8) sampled residents (Resident 7). This deficient practice placed the resident at risk for a delay in detecting if the resident had a non-functioning arteriovenous shunt (AV- a connection or passageway between an artery and a vein used for hemodialysis) and a delay in detecting complications including infections, bleeding and/or nausea and vomiting. Findings: During a review of Resident 7's Admission Record, the record indicated Resident 7 was admitted to the facility on [DATE]. Resident 7's diagnoses included End Stage Renal Disease ([ESRD] condition which a person's kidneys cease functioning on a permanent basis leading to the need for dialysis or kidney transplant to maintain life), diabetes mellitus (irregular blood sugar), hypertension (high blood pressure), hyperlipidemia (high level of fats in the blood), and atherosclerotic heart disease (build up of fats, cholesterol, and other substances in and on the artery walls). During a review of Resident 7's Minimum Data Set (MDS), a comprehensive assessment and care screening tool, dated 8/3/2021, the MDS indicated Resident 7's cognitive (mental action or process of acquiring knowledge and understanding) function was intact. The MDS indicated Resident 7 required extensive assistance with one to two persons assist with bed mobility, transfer, dressing, toilet use and personal hygiene. He requires limited assistance for eating. During observation, interview, and record review on 12/13/2021 at 12:56 p.m., Resident 7 stated he started HD five (5) months ago, but his dialysis this morning was rough. Resident 7 stated he started vomiting thirty (30) minutes after starting HD and had to be stopped for ten (10) minutes. Resident 7 stated he vomited again about an hour ago upon return to the facility. Resident 7 stated that staff was aware that he vomited and just does not feel right and feeling bad. He stated he felt dizzy, lightheaded and like he's getting sick. Resident 7 further stated that staff did not assess his AV shunt or take his vitals after he came back from HD. Resident 7 proceeded to show his 'Dialysis Communication Record' dated 12/12/2021, which indicated post dialysis assessment section was not filled out. During observation on 12/13/2021 at 1:24 p.m., Resident 7 grabbed a plastic bag and started vomiting. He then hit the call light to summon staff. During observation, interview, and record review on 12/13/2021 at 1:35 p.m., License Vocational Nurse (LVN 16) stated Resident 7 arrived at approximate 12:15 p.m. today, but she did not assess him as soon as he arrived because she was helping with meals. She stated she saw him at the entrance and Resident 7 informed her that he was not going out for an outing because he was not feeling well. LVN 16 confirmed she should have assessed him right there and then, especially because he was not feeling good. She stated that they're suppose to do an assessment and take vital signs before and after HD. It's important to assess AV shunt site for bleeding, vital signs and other sign and symptoms which may indicate infection or electrolyte imbalance. (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

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of care plan 'The resident needs hemodialysis r/t ESRD' initiated 7/28/2021, indicated that The resident will have immediate intervention should any s/sx of complications from dialysis occur . Facility could not provide a policy and procedure for Post Hemodialysis Resident Care. A review of facility's policy and procedure (P&P) titled 'Change in a Resident's Condition or Status,' revised 12/2021, indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); impacts more than on area of the resident's health status; requires interdisciplinary review and/or revision to the care plan . A review of facility's policy and procedure (P&P) titled 'Hemodialysis Access Care,' revised 9/2010, indicated that documentation should include location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post dialysis being given, and observations post dialysis.

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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42243 Based on interview and record review, the facility failed to provide sufficient staffing to accommodate the needs of 6 of 6 sampled residents (Residents 24, 49, 59,87, 88, 106) by failing to ensure: 1. Resident call lights were answered for activities of daily living ([ADLs] personal hygiene, getting dressed, and bathing) in a timely manner for Residents 24, 49, 59, 88, 106 2. Restorative Nursing Assistance (RNA) services ([RNA] care that emphasizes the evaluation of residents' underlying capabilities with regards to function and helping them to optimize and maintain functional abilities) was provided to Resident 87. These deficient practices caused feelings of discomfort, and frustration for 6 of 6 sampled residents and had the potential to affect 122 Residents that could lead to accidental falls, hypoglycemia (low blood sugar), unresolved pain, thirst, hunger, not meeting the residents' needs and negatively affecting the resident's quality of life. Findings: 1a. A review of the facility's resident council (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care and quality of life) meeting minutes dated 6/30/2021, 7/29/2021, 8/31/2021, 9/2021, 10/29/21 and 11/29/2021 indicated the residents' concern included call lights not answered in a timely manner, on 7/29/2021 resident council had concerns about staff not checking on residents in their rooms. On 10/29/2021 resident council meeting had concerns about snacks not getting delivered timely during the 3 to 11 p.m. shift. On 12/14/21 at 10:34 a.m., during the resident council meeting (Residents 24, 49, 59, and 88) 4 of the 6 alert residents who attended the Resident Council Meeting stated call lights were not answered in a timely manner and residents did not get the help and care they needed without waiting a long time. The residents felt the facility was understaffed. The residents stated it takes about an hour to get someone to answer the call light. During a review of Resident 24's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/25/2021, indicated the resident was mildly impaired of cognitive (ability to think, understand and made daily decision) skills and was able to understand and understood others During a review of Resident 49 MDS dated [DATE], indicated the resident had no cognitive impairment. During a review of Resident 59 MDS dated [DATE] indicated the resident had no cognitive impairment During a review of Resident 88 MDS dated [DATE] indicated the resident had no cognitive impairment (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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During resident council meeting on 12/14/21 at 10:34 a.m., Resident 88 stated during the night shift (11:00 p. m. - 7:00 a.m.), the facility was short staffed and only had one nurse to administer medications and 4 Certified Nurse Assistants (CNAs) and took about 22 minutes for call light to be answered and it felt like it takes a while to get assistance. During resident council meeting on 12/14/2021 at 11:15 a.m., Resident 49 stated staff did not offer care/assistance because she was self-sufficient and was not being asked if she needed help and felt ignored. Resident 49 stated on 12/14/2021 she called for assistance and it took 1 hour to get someone to help to assist going to Resident Council Meeting. 1b. During an interview on 12/13/21 at 11:28 a.m., Resident 106 stated there was not enough staff at night, especially during the last shift and response time to answer call light was slow. Resident 106 stated he pressed the call light on 12/13/2021 at 3:00 a.m., and it took the staff two hours to respond to answer call light. Resident 106 stated he needed assistance changing his colostomy bag (a plastic bag that collects fecal matter from the digestive tract through an opening in the abdominal wall called a stoma) because the seams of the colostomy bag were busted. Resident 106 stated when his colostomy was busted, and fecal matter was leaking all over, he felt helpless and frustrated. During a review of the Resident 106's admission record (Face sheet), indicated the resident was admitted to the facility on [DATE], with diagnoses not limited to end stage renal disease ([ESRD] the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life), malignant neoplasm of the colon (cancer of large intestine), heart failure (a condition in which the heart has trouble pumping blood thought the body), type 2 diabetes (abnormal blood sugar levels), and hyperlipidemia ([HLD] a condition that causes the levels of certain bad fats, or lipids, to be too high in the blood). During a review of the Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 10/21/21, indicated Resident 106 had no cognitive impairment; required one-person assistance from staff with bed mobility, dressing, and toileting; and total dependence on staff with bathing. During a review of Resident 106's history and physical (H&P), dated 10/15/21, indicated Resident 106 had the capacity to understand and make decisions. During a review of Resident 106's physician orders, dated 12/16/21, indicated the resident had orders for colostomy site to be cleaned and colostomy bag to be changed as needed for leakage or dislodgement. During an observation on 12/14/21, at 8:50 a.m. at Resident 106 bedside, Licensed Vocational Nurse (LVN 12) was observed changing Resident 106's colostomy bag. Colostomy bag appeared inflated and Resident 106 told LVN 12 there was lots of air and leakage from the bag because it took so long for nursing staff to change it. An abdominal wound dressing on Resident 106, was slightly soiled with a brown substance that appeared to be from the contents if the colostomy bag. Resident 106 told LVN 12 he could not sleep when his colostomy bag was busted and was afraid his abdominal wound can get infected to the point of hospitalization . (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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/14/21 at 9:10 a.m., LVN 12 stated there was a little bit of leaking to colostomy bag that had soiled part of the abdominal dressing. LVN 12 verified, if the colostomy bag was not changed timely, the colostomy bag could leak into the abdominal dressing and could cause the abdominal wound to get infected. LVN 12 stated she informed nursing staff before that they need to change the colostomy bag immediately when it is leaking. During a review of the facility's policy and procedure (P/P) titled, Answering the Call Light revised March 2021, indicated the purpose of answering call light was to ensure timely responses to the resident's requests and needs. Some residents may not be able to use their call light and to be sure to check these residents frequently. If the request is something that can be fulfilled, complete the task within five minutes if possible and if the Resident request cannot be fulfilled ask the nurse supervisor for assistance. 2.During a concurrent record review of nursing assignment sheets and census (number of residents in the facility) in the skilled-nursing facility (SNF) department for random dates with, assistant staff developer (ASD) on 12/21/at 10:00 a.m., ASD stated they were short staffed on the following days: a. 11/7/21, 4 CNAs, 2 LVNs, 1 RN assigned to 100 residents for 11:00 p.m. to 7:00 a.m. shift b. 11/13/21, 4 CNAs, 2 LVNs, 1 RN assigned to 105 residents for 11:00 p.m. to 7:00 a.m. shift c. 11/25/21, 4 CNAs, 2 LVNs, 1 RN assigned to 107 residents for 11:00 p.m. to 7:00 a.m. shift d. 12/16/21, 5 CNAs, 2 LVNs, 1 RN assigned to 104 residents, but 1 CNA called off for 11:00 p.m. to 7:00 a.m. shift e. 12/18/21, 4 CNAs, 3 LVNs, 1 RN assigned to 101 residents for 3:00 p.m. to 11:00 p.m. shift 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) that she did not have adequate staffing, but they were not able to provide additional staff and just had to work with the staff they had. ASD stated for census of 103 they should have 6 CNA at night shift and assigned to maximum of 16 to 21 residents but sometimes they have 26 residents each CNA and that was a lot for 1 CNA. ASD stated they need to have adequate staff for safety of residents, CNAs were tired, and they could get hurt if they were tired and we are going to lose staff if we are always short staff. During an interview on 12/21/21 at 11:30 a.m., DON stated he was aware that there were days some staff called in sick but unable to find replacement. DON stated they tried to call other staff to come in to work but no one was available. DON acknowledged he did not try to reach out to their sister company, call a registry (agency that provides staffing as needed), nor reached out to any other agency. DON stated they do not have a registry they worked with and only tried to work with the staff they have on their roster. (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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review of Census and Nursing Hours per Patient Day ([NHPPD] form indicating projected daily nursing hours) for random nursing hours with Director of Nursing (DON) on 12/22/21 at 11:02 a.m., DON stated the NHPPD indicated they were not meeting the required 3.5 nursing hours on the following day because they were short staffed: a. On 11/13/21 final NHPPD was 2.92 b. On 11/25/21 final NHPPD was 2.85 c. On 12/16/21 final NHPPD was 2.52 d. On 12/18/21 final NHPPD was 2.69 DON stated it was important to ensure they met the required 3.5 NHPPD in order to meet the overall needs of the residents, and to be compliant with regulations. During an interview on 12/22/2021 10:50 a.m., with ADM, ADM stated if they were short staffed, it was their process to ask staff to stay over, call off duty staff, and stated they have a contract with registry who can be reached 24 hours a day, 7 days a week. ADM stated he was not aware of the staffing shortage and if he was informed, he would have called a registry, use Reddinet a tool that maybe used by the facility to communicate situational information to the county or to MHOAC [(Medical and Health Operational Area Coordinator) Local Emergency Medical Services agency] and report facility status. During a review of the facility's COVID-19 Mitigation Plan [(MP) a plan to reduce the spread of the COVID-19 virus), undated, the MP indicated it is the policy of the facility to maximize the staff availability and utilize these approved staffing registries if they were unable to cover staffing needs during an emergency. If this strategy does not meet the facility's needs, facility may request additional staff through Medical Health operational Area Coordinator program. 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. 3. During a review of Resident 87's Face Sheet, the face sheet indicated Resident 87 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 87's diagnoses included unspecified osteoarthritis (joint disease that happens when the tissues in the joint break down over time), muscle weakness, abnormalities of gait and mobility, and major depressive disorder (it affects how one feels, thinks and behaves and can lead to a variety of emotional and physical problems.) During a review of Resident 87's MDS, dated [DATE], indicated Resident 87's cognitive skills for daily decisions making were mildly impaired, and required limited assistance of one-person physical assist for activities of daily living. A record review or Restorative Nursing Flowsheet for December 2021 indicated an order for Restorative Nurse Assistant (RNA) for PROM (Passive Range of Motion) to Bilateral Lower Extremity every day five times a week or as tolerated. (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

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/20/21, at 3:23 p.m., (RNA 1), stated facility had a shortage with Certified Nurse Assistant, and RNA's were asked to work both as CNA and RNA at the same time, which was a heavy workload and as a result, they could not complete the RNA tasks as ordered. RNA 1 stated this has been brought up several times to Assistant Staff developer (ASD) who was in charge of staffing, but nothing has been done and RNA's continued to be scheduled as CNA's at the same time. RNA 1 acknowledged if the facility continued not to provide RNA services as ordered this would cause residents to be at risk for a decline in mobility and possibly in health as well. During a concurrent interview and record review of Restorative Nursing Flowsheet dated December 2021 with RNA 1 on 12/20/21 at 3:30 p.m., RNA1 stated Resident 87's Restorative Nursing Flowsheet indicated from 12/1/2021 to 12/14/2021 Resident 87 only received RNA services 8 out of 10 times. RNA 1 confirmed Resident 87's order indicated RNA services were to be done daily five times a week and admitted RNA services were not provided to Resident 87 two of the ten occurrences and stated the 2 days RNA services were not provided to Resident 87 were days when RNA 1 was required to work as both an RNA and CNA and were not able to perform RNA service to Resident 87. During a concurrent interview and record review of Restorative Nursing Flowsheet dated December 2021 with Physical Therapy Aide (PTA 1) on 12/20/21, at 4:18 p.m., PTA 1 stated Resident 87's Restorative Nursing Flowsheet, dated December 2021, was reviewed. The Restorative Nursing Flowsheet for Resident 87 indicated, from December 1st to December 14th, Resident 87 only received RNA services 8 out of 10 times. PTA 1 stated that documentation confirms that RNA services weren't provided on December 3rd, December 7th, December 10th, December 12th, and December 14th. PTA 1 stated orders indicated RNA services should be done daily 5x/wk. PTA 1 confirmed that Resident 87 missed RNA services twice on two different occasions between December 1st to December 14th. PTA 1 stated if RNA care was not completed per orders, residents are at risk for a physical and mobility decline leading to contractures and deep vein thrombosis (DVT). PTA 1 stated RNA's are supposed to report to Physical Therapists when there is a decline in resident's health or if services cannot be provided. PTA 1 stated that PTA 1 was unaware that Resident 87 has not received RNA therapy as ordered. During a review of the facility's P/P titled, Staffing, revised October 2017, the P/P indicated the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents' care plans and the facility assessment. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. Staffing numbers and the skills requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Other support services like activities/recreational, therapy is also staffed to ensure that residents needs are met.

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

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43906 Based on observation, interview and record review, the facility failed to ensure staffing information was updated and posted in a visible and prominent place, accessible to staff, residents and visitors daily. This deficient practice resulted in inaccessibility of the accurate daily number of clinical staff taking care of residents, daily. Findings: During an observation on 12/20/21, at 12:50 p.m., the Census and Nursing Hours per Patient Day (NHPPD), form indicating projected daily nursing hours, dated 12/20/21 was posted outside of the nurse's station indicating the beginning patient census for the day was 99. During an interview and record review on 12/20/21, at 12:55 p.m., with Assistant Staff Developer (ASD), ASD stated she or the registered nurse (RN) supervisor can fill out the Census and NHPPD form. ASD stated the form is posted so anyone can view it and is important to be completed every day to predict staffing hours of the day for licensed nurses and certified nursing assistants (CNAs). ASD reviewed form for 12/20/21 and stated it was not completed, because sometimes staff calls off and she is not sure who is going to work, so she would not complete the form. During an interview on 12/17/21, at 10:40 a.m. with Director of Nursing (DON), the DON stated staffing hours for CNAs, licensed vocational nurses (LVNs), and RNs, are supposed to be posted daily for the public as part of the regulation. A review of the facility's policy, Posting Direct Care Daily Staffing Numbers, revised 7/2016, indicated within 2 hours of the beginning of each shift, the number of licensed nurse (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include the following: the resident census at the beginning of the shift for which the information is posted, 24-hour shift schedule operated by the facility, the shift for which the information is posted, type (RN, LPN, LVN, or CNA) and category (licensed and non-licensed) of nursing staff working during that shift; the actual time worked during that shift for each category and type of nursing staff, and the total number of licensed and non-licensed nursing staff working for the posted shift.

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43906 Based on observation, interview and record review, the facility failed to: a. Accurately account for the waste of two vials (a small glass container used for medication storage) of one controlled medication (medications with a high potential for abuse, in the Controlled Drug Record (a log signed by the nurse with the date and time of each instance a controlled medication is given to a resident) for Resident 11. b. Ensure controlled medications received from outside the facility were checked and discarded for Residents 68 and 111. These deficient practices increased the facility's risk for potential loss, diversion (transfer of a medication from a legal to an illegal use) or accidental exposure to controlled medications, and potential for harm to residents. Findings: a. During a concurrent observation and interview of the controlled medications awaiting disposition (destruction) and record review on 12/15/21, at 9:11 a.m., with Director of Nursing (DON), there were six vials of Ativan (medication used to treat anxiety) 2 milligrams (mg)/milliliter (ml) for Resident 11. A record review of Resident 11's Controlled Drug Record indicated the dosage of medication to be given is 0. 5 milliliters ([ml] 1 mg). Controlled Drug Record indicated on: 10/6/21 at 10:40 a.m., 0.5 ml of Ativan 2 mg/ml was administered, no record for the rest of the contents in the vial, which should have been the amount wasted (irretrievably disposed of). 10/7/21 at 7:03 a.m., 0.5 ml of Ativan 2 mg/ml was administered, no record for the rest of the contents in the vial, which should have been the amount wasted. DON stated an Ativan vial is used once per dose and cannot be kept even if there is left over medication. DON confirmed the rest of the medication in the Ativan vial is supposed to be wasted in the presence of two nurses and documented on the Controlled Drug Record. A review of the facility's policy (P/P), Controlled Substances, revised 4/2019, indicated upon disposition, if a resident received partial tablets or single dose ampules (or it is not administered), the medication may not be returned to the container. Medications that are opened and subsequently not given (refused or partially administered) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. (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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a concurrent observation of Medication Cart Station #2 and interview on 12/15/21, at 10:53 a.m., Licensed Vocational Nurse (LVN 5), one hydrocodone-acetaminophen (medication used to treat pain) 5-325 mg medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) was observed in the locked area of the cart. Medication card indicated it was from an outside pharmacy. Medication card label indicated a quantity of 10 tablets were dispensed. Medication card contained 7 tablets with holes punched out from #8, #9, #10 bubbles. 1. A record review of the Controlled Drug Record indicated that the medication card on hand started with 7 tablets. Controlled Drug Record indicated the resident name, medication name, medication strength, and prescription number, but did not indicate physician name, name of issuing pharmacy, quantity received, and date/time received. During an interview with LVN 5, the LVN stated the Controlled Drug Record indicated there are seven tablets in the medication card. LVN 5 stated LVN 14 gave her the medication card and Control Drug Record when Resident 11 was moved from station 1 to station 2. LVN 5 stated the Control Drug Record is not accurate and is a problem because she does not know where the three tablets from bubbles #8, #9, and #10 are. During an inspection of Medication Cart Station #1 on 12/15/21, at 11:28 a.m., with LVN 13, no other Control Log Record was found for the hydrocodone-acetaminophen 5-325 mg dispensed from outside pharmacy. During an interview on 12/15/21, at 11:22 a.m. with RN 5, the RN stated controlled medications come from the pharmacy with a Controlled Drug Record, and licensed nurse that receive medication would verify amount with another licensed nurse. RN 5 stated there is no record of the original Control Drug Record from pharmacy, and the issue is that it cannot be determined if medication was given at facility or not. RN 5 stated if there are discrepancies, licensed nurse should notify the RN supervisor or DON. During an interview on 12/16/21, at 4:00 p.m. with DON, the DON stated he was not able to verify if three hydrocodone-acetaminophen tablets dispensed from outside pharmacy were given at facility. DON stated he was trying to verify if tablets was given at Resident 11's previous facility but could not give an answer if they were or not. 2. During an inspection of Medication Cart Station #3 on 12/15/21, at 3:32 p.m. with LVN 15, one bottle of clonazepam (medication used to treat anxiety) 1 mg tablets, one bottle of quetiapine (medication used to treat certain mental/mood disorders) 50 mg tablets, and one bottle of quetiapine 400 mg tablets for Resident 111 was observed in the locked area of the cart. LVN 15 stated when resident comes back with controlled medications from the doctor, staff keep them in the medication cart, so it is not stored in the residents' room. LVN 15 stated if resident comes to the facility with controlled medications prescribed elsewhere, it should be reported to the registered nurse (RN) to ensure the medications are not being used by another resident. LVN 15 stated she will only give medications to residents dispensed from facility's pharmacy. (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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/15/21, at 3:29 p.m. with RN 5, the RN stated controlled medications from outside the facility are supposed to be turned into the DON, especially if it was from a different pharmacy. RN 5 stated staff can only give residents medication coming from the facility's pharmacy. RN 5 stated controlled medications that were found in the carts were not properly logged upon possession, so is uncertain if those medications were tampered with. RN 5 stated if controlled medications were found in the medication cart, they were not given to the DON right away. During an interview on 12/16/21, at 4:00 p.m. with DON, the DON stated the process for residents who come to the facility with controlled substances from the outside are to be stored with him for safekeeping. If resident is long-term, the controlled medication must be disposed, and facility's pharmacy will be able to reconcile and dispense. DON stated if controlled medications that are from outside pharmacy were found in the medication cart, they were not turned over and accounted for through documentation. During an interview on 12/21/21, at 10:15 a.m. with DON, the DON stated it is important to account for controlled medications received from outside of the facility. DON stated it is important for accountability, to know the exact number of medications residents come in with, so it is not being given out. DON stated it is important for controlled medications to be stored properly or disposed of because those medications will be reordered at the facility. A review of the facility's policy, Controlled Substances, indicated controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. At the end of each shift any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately. A review of the facility's policy, Medication Ordering and Receiving from Pharmacy, dated 8/2014, indicated medications brought into the facility by a resident or family member are used only upon written order by the resident's attending physician, after the contents are verified if required, and if the packaging meets the facility's guidelines. Unauthorized medications are not accepted by the facility. The medications received directly from another health care facility e.g., discharge medications arriving with the resident from an acute hospital, or those drugs dispensed or obtained after admission from a physician, or any licensed or governmental pharmacy are not subject to pharmacist verification. Medications not ordered by the resident's physician, or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within thirty days, the medications are disposed of in accordance with facility medication destruction/disposal procedures.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview, and record review, the facility failed to: 1. Label three multi-dose Tuberculosis ([TB] a potentially serious contagious, infectious disease that mainly affects the lungs) vaccine (medication that provides immunity [ability to resist infections]) vials (glass container for medication) with an opened date (the date it was first used, which would determine the expiration date). 2. Discard one over-the-counter medication after expiration. 3. Dispose Ipratropium Bromide (medication used to open the airways of the lungs) in a timely manner for one out of two sampled residents reviewed under the facility task of medication storage (Resident 23). 4. Re-order and replace items for one emergency kit ([e-kit] box containing a small quantity of medications that can be dispensed when pharmacy services are not available) after opening. 5. Properly log removed medication from the e-kit. These deficient practices had the risk that residents may receive medication that had become ineffective or toxic due to improper storage or labeling and may have not received medications due to emergent unavailability, possibly leading to health complications resulting in hospitalization or death. Findings: 1. On [DATE], at 8:26 a.m., during a concurrent inspection of the medication room and interview with Registered Nurse (RN 5), 3 multi-dose TB vaccine vials were found in the refrigerator with no open date. RN 5 stated opened TB vials must have a label with date and time it was opened to ensure medication is not expired for administration. During an interview on [DATE], at 10:15 a.m. with Director of Nursing (DON) the DON acknowledged TB vaccines had to be labeled with an open date because it is only good for a certain number of days. DON stated TB vaccines are supposed to be disposed of after 30 days. DON stated it is best practice to discard them if found with no open date, reorder and replace it. A review of the manufacturer's instructions indicated a vial of Tubersol (Brand Name for TB Vaccine) which has been opened and in use for 30 days should be discarded. Do not use after expiration date. 2. On [DATE], at 3:32 p.m., during an inspection of Medication Cart #3 with LVN 15, one bottle of B-Complex Plus Vitamin C with expiration date ,d+[DATE] was found. (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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On [DATE], at 10:02 a.m., during an inspection of Medication Cart on sub-acute unit and interview with LVN 7, one Ipratropium/Albuterol (medication used to open airway to help control symptoms of lung diseases) with open date [DATE] was found. LVN 7 confirmed after opening the medication, it has only 28 days to be used from the opened date and medication should have been discarded. During an interview on [DATE], at 4:00 p.m. with DON, the DON stated, for medications with expiration date , d+[DATE], the medication was good until the end of that month. DON stated medications that expired were supposed to be discarded. A review of the facility's policy (P/P), Administering Medications, revised ,d+[DATE], indicated the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. A review of the facility's P/P, Discarding and Destroying Medications, revised ,d+[DATE], indicated medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceutical, hazardous waste and controlled substances. 4. On [DATE], at 11:16 a.m., during an inspection of the medication room and interview with LVN 5, one e-kit was found secured by a yellow tab. LVN 5 stated if there is a yellow tab securing the e-kit, it means that it was opened. During an interview on [DATE], at 12:28 p.m. with RN 5, the RN verified yellow tab securing the e-kit meant it was opened and if a red tab is securing e-kit it meant it was from the pharmacy. RN 5 stated once an e-kit had been opened, it should be replaced by the following day, but at most within 48 hours. RN 5 stated licensed nursing staff were supposed to be calling the pharmacy for the replacement. RN 5 stated that there is no evidence that a new e-kit was requested. During an interview on [DATE], at 10:15 a.m., with DON, the DON stated the last day the e-kit was ordered was on [DATE]. DON stated e-kit must be replaced as soon as possible from pharmacy to have complete emergency medications. DON stated it is important to have medications in case residents need it and are not available. During an interview on [DATE], at 9:42 a.m., with facility's pharmacy customer service representative, the representative stated the last e-kit the facility ordered was on the morning of [DATE] and was sent out that evening. Representative stated no e-kit was ordered or delivered after that day. 5. During a concurrent interview and record review on [DATE], at 12:28 p.m. with RN 5, the RN stated the process when opening an e-kit is to notify the pharmacy the need for removing the medication from the e-kit and to log the medications being dispensed on the Emergency Kit Pharmacy Log found inside the e-kit. RN 5 stated the Emergency Kit Pharmacy Log will consists of two copies, the white copy is placed in a binder, stored inside the facility's medication room, and the yellow copy is placed back into the e-kit for pharmacy to know what medication was removed. A review of the white copy of Emergency Kit Pharmacy Log record indicated one Bactrim (antibiotic medication) ,d+[DATE] milligrams (mg) DS tablet was removed on [DATE] at 8:00 p.m. (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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the yellow copy of Emergency Kit Pharmacy Log record indicated one Bactrim ,d+[DATE] mg DS tablet was removed on [DATE] at 8:00 p.m. and two Azithromycin (antibiotic medication) 250 mg tablets were removed on [DATE]. An inspection of the e-kit indicated there were 3 Bactrim/Septra DS ,d+[DATE] mg tablets and two Azithromycin 250 mg tablets remaining. A record review of the drug supply list inside the e-kit indicated there was a total of 4 Bactrim DS/Septra DS , d+[DATE] mg tablets and 4 Azithromycin 250 mg tablets. A review of the facility's policy, Medication Ordering and Receiving from Pharmacy, dated ,d+[DATE], indicated when an emergency or state dose of medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency e-kit slip and re-seal the emergency supply. An entry is made in the emergency log book containing all required information. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply. A record of the name, dose of the drug administered, name of the patient, date, time of the administration, and the signature of the person administering the dose shall be recorded in the emergency log book. The used sealed kits are replaced with the new sealed kits within 72 hours of opening.

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

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42243 Based on observation, interview and record review, the facility failed to provide food preferences for one of eight sampled residents (Resident 92). This deficient practice had the potential to result in decreased meal satisfaction and decreased overall caloric intake. Findings: During a review of Resident 92's Admission Record (Face Sheet), the face sheet indicated Resident 92 was admitted to the facility on [DATE]. Resident 92's diagnosis included Hemiplegia (paralysis of one side of the body), weakness, abnormalities of gait and mobility. During a review of Resident 92's Minimum Data Set (MDS), a resident assessment and care planning tool, dated 10/19/2021, the MDS indicated Resident 92 was mildly cognitively (ability to think, understand and made daily decision) impaired and was able to understand and understood others. The MDS indicated Resident 92 required supervision and one-person physical assist for eating. During a concurrent observation and interview on 12/19/21 at 8:15 a.m. at Resident 92's room, Resident 92 stated she could not eat eggs because it upset her stomach. Resident 92 stated she had asked multiple times not to have eggs on her tray. Resident 92's breakfast tray was observed with two boiled eggs. The diet meal ticket indicating on Resident 92'meal tray indicated Resident 92 was not to have eggs. Resident 92 stated she had spoken to management on several occasions regarding her food preferences, but no changes had been made. During a review of Resident 92's physician orders summary report indicated an order dated 5/14/2021 for Regular-NAS (No Added Salt) diet, no eggs, no cheese, and no milk. During a current observation and interview on 12/19/2021 at 08:20 a.m., CNA 22 stated she delivered the breakfast tray to Resident 92's room and it had 2 boiled eggs on the tray. CNA 22 stated she only checked the resident's name on the breakfast tray to ensure the correct tray was given to the resident but she did not compare what diet was written on the meal ticket and what was on the breakfast tray. CNA 22 stated Resident 92 did not request for eggs and does not know why they gave her eggs when the meal ticket indicated no eggs and giving her food that she was not supposed to eat was not good because resident might have allergy or can get sick. During a concurrent observation and interview on 12/19/2021 at 08:24 a.m., LVN16 stated he was responsible for checking the meal trays and the dietary meal ticket, resident name, diet order and compare against what was on the meal tray. LVN 16 stated he did not catch that there were two boiled eggs on Resident 92's breakfast tray and had missed the instruction on the dietary meal ticket that indicated Resident 92 cannot have eggs. LVN16 stated it was important to check the meal ticket to ensure resident received the appropriate diet ordered, food preference and restrictions for resident safety and respect resident food preferences and wishes and encourage eating. (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

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 92's dietary meal ticket for 12/19/2021 with Dietary Aide 1 on 12/19/21 at 10:20 a.m., Cook 2 stated Resident 92 did not request for hardboiled egg but sent Resident 92 a breakfast tray with two hardboiled egg because she remembered resident liked hardboiled egg with, harsh brown and bacon without checking the diet order or food preference prior to preparing Resident 92's breakfast meal. Cook 2 stated Resident 92's meal ticket indicated the resident should not have hardboiled egg and does not know why resident cannot have eggs, but she should follow the order because resident might have allergy that could make resident sick. Cook 2 confirmed it was important if a resident requested a food preference, the facility needed to follow it, to respect the resident's wish to eat what they wanted. During an interview on 12/19/2021 at 12:30 p.m., Director of Nursing (DON) stated they had an interdisciplinary team meeting (multi-disciplinary care conference) with Resident 92 and Resident 92's son and have discussed food preferences and have listed eggs, cheese and milk as something she did not like and did not mention why Resident 92 did not like eggs and have updated the Diet order not to have eggs, cheese and milk. DON acknowledged dietary and nursing staff should have checked the order and they should have not given Resident 92 eggs and followed the order and respect resident preference and respect the resident wish. During a record review of the Resident 92's multidisciplinary care conference notes dated 11/30/2021, indicated Resident 92 Dietary preferences/ restrictions included no added salt therapeutic diet (NAS), Resident verbalized she dislike eggs, cheese and milk and Resident 92 and Resident 92's son requested to have no eggs, cheese and milk in the diet order. During a record review of Resident 92's care plan for potential nutritional problems initiated on 8/1/2021 indicated interventions to provide, serve diet as ordered, Regular-NAS diet, regular texture, thin consistency, no eggs, no cheese, no milk. During a review of the facility's policy and procedure (P/P) titled, Resident Food Preferences, revised July 2017, the P/P indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. During a review of the P/P titled, Therapeutic Diets, revised October 2017, the P/P indicated therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care in accordance with his or her goal and preferences. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. During a review of the P/P titled, Tray Identification, revised April 2007, the P/P indicated to assist in setting up and serving the correct food trays/diets to residents, the Food Services Department will use appropriate identification e.g computer generated diet cards to identify the various diets. The Food Services Manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the residents. If there is an error, The nurse supervisor will notify the Dietary Department immediately by phone so that the appropriate food tray can be served.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42380 Based on observation, interview and record review, the facility failed to follow proper sanitation and food handling practices by failing to: 1. Ensure that dietary staff knew how to calibrate (correlate the readings of an instrument with those of a standard to check the instrument's accuracy) of the food thermometer used per facility policies and procedures in order to identify the proper temperatures of the food being served. 2. To clean the thermometer in between food trays while checking food temperature. 3. To ensure personal protective equipment was properly worn during tray line. These deficient practices had the potential to result in foodborne illnesses (also called food poisoning caused by eating contaminated food or eating food not kept at appropriate temperatures) for all residents living in the facility. Findings: During a concurrent tray line observation and interview on 12/14/2021 at 11:45 a.m., Cook (Cook1) was not able to demonstrate how to calibrate the food thermometer to show accuracy. Cook 1 stated that he puts the thermometer in hot water to clean it and when it hits 20 degrees then he knows it's clean and ready. Cook 1 then went to grab another thermometer from a shelf and tried to put that thermometer in a bucket with ice. Cook 1 could not verbalize the process of how to check the thermometer for accuracy. Dietary Supervisor (DS) came to aid Cook 1 and stated that digital thermometers do not need to be calibrated, however DS could not verbalize how to check thermometer for accuracy. During tray line observation on 12/14/2021 at 12:10 p.m., Cook 1 did not wash his hands and change his gloves before proceeding to check food temperature after grabbing another thermometer from a shelf and breaking tray line. Cook1 also failed to clean the thermometer in between different food tray temperature checks. During tray line observation on 12/14/2021 at 12:10 p.m., Dietary Aide (DA1) was observed helping with tray line with her mask sitting right below her nostrils until the last tray was prepared. During an interview on 12/14/2021 at 1:05 p.m., Cook1 confirmed that he should have washed his hands and changed gloves because he broke tray line by leaving to grab things away from tray line. He also stated that he usually uses alcohol wipes to clean the thermometer in between food trays to prevent food contamination. Cook1 stated these infection control measures are important to keep resident safe from getting sick from the food. During an interview on 12/14/2021 at 1:10 p.m., DA1 stated that she did not notice her mask was sitting below her nostrils. DA1 then pulled up her mask and stated that she will make sure to always keep it over her nose. She stated that it's important to have her mask on properly to prevent germs or virus from getting in the food being prepared for the residents, because it can make them sick. (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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/14/2021 at 2:23 p.m., DS stated she did not know how to check for thermometer accuracy. She verified the thermometer should have been cleaned in between food trays. DS stated if dietary staff in the tray line leave the tray line to grab things then they must wash their hands and change gloves before they restart working on the tray line. DS stated that dietary staff masks should be worn properly to always cover the mouth and nose. All this is to prevent germs from getting in the residents' food and prevent sickness. During an interview on 12/16/2021 at 03:34 PM, Dietary Consultant (DC) stated that dietary staff should know how to use the thermometer and that even digital thermometers need to be calibrated. She stated dietary staff should know how to check for thermometer accuracy and DS should be the one doing the in-services (staff education) for that. DC stated that thermometers should be cleaned in between food tray temperature check to prevent food contamination. She stated there might be food that are not cooked that touches the cooked food or contaminate food that a resident may have an allergy to. DC stated the infection preventionist (IP) does the appropriate use of masks in-services, but she stated that dietary staff should always have their mask over their nose and mouth and not under the nostrils. Facility could not provide documentation of in-services for dietary staff regarding thermometer use. A review of facility's policy and procedure (P&P) titled 'Food Preparation and Service,' revised 10/2017, policy statement indicted food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices It further indicated Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness .Thermometers will be placed in hot and cold storage areas and checked for accuracy in accordance with accepted public health standards .The temperature of foods held in steam tables will be monitored by food and nutrition services staff .Food and nutrition services staff, including nursing services personnel, will wash their hands before serving food to residents. Employees also will wash their hands after collecting soiled plates and food waste prior to handling food trays .Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use. A review of facility's P&P titled 'Meal Temperatures,' undated, indicated that prior to dispensing of meals, the food will be tested for proper temperatures. A probe or digital thermometer will be used to record food temperatures for the current meal served. The thermometer shall be calibrated at least weekly by either ice point method (preferred) or boiling point method. *Ice Point Method: Fill a glass with ice; add water to the top of the glass. Place the thermometer in the glass. Wait 30 seconds. The temperature should register 32 F (0 C). Adjust the nut on the thermometer if needed. *Boiling Point Method: Bring clean tap water to a boikl I deep container. Place thermometer in the boiling water. Do not touch the sides or bottom of the pan. Wait 30 seconds. The temperature soul dread 212 (degrees) F (100 C) at sea level. Adjust the nut on the thermometer as needed. (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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility's P&P titled 'Meal Temperatures,' undated, indicated that proper sanitizing procedures for use of the thermometer need to follow. Wipe the thermometer with a clean paper towel or disinfecting solution between food items. After temperatures are recorded: clean the thermometer by wiping it with a clean paper towel. Then immerse in 180 deg F hot water for 30 seconds. Allow to air dry OR clean thermometer with hot, soapy water. Wipe with alcohol swab or dip in disinfecting solution at least 50 PPM and allow to air dry. A review of facility's P/P titled 'Food Allergies and Intolerances', dated 8/2017, indicated steps are taken to prevent resident exposure to allergens(s) .meals for residents with severe food allergies are specially prepared so that cross-contamination with allergens does not occur. A review of facility's P/P titled 'Food [NAME] by Family/Visitors' dated 10/2017, indicated all personnel involved in preparing, handling, serving or assisting with meals or snacks will be trained in safe food handling practices.

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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 42243 Based on observation, interview, and record review, the facility failed to assess, document, and implement the Facility Assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The facility failed to: 1. follow its own policy to ensure the staff had the knowledge base, capability, and capacity to perform their duties by failing to demonstrate competency with infection control and abuse policies. 2. ensure facility has sufficient staff to assure residents' care and safety needs were met. 3. provide a safe, functional, sanitary, and comfortable environment for 122 residents, staff, and visitors, by not maintaining the facility's roof, resulting in multiple water leaks from the ceiling in the dining room (also used for activities) and nurses' station. These deficient practices had the potential for 122 of 122 residents who resided in the facility not being assisted timely or at all, not receive medically related care and services, which could cause serious injury, harm, impairment, or death., or had the potential to negatively affect the quality of life due to the leaking ceiling. Findings: 1a. During an observation and interview from 12/13/2021 to 12/22/2021, Facility failed to educate at least two Family members (FM1 and FM2) regarding what were the required infection control policies to follow when visiting resident (Resident 170) on clostridium difficile ([C-diff] a contagious infection, inflammation of the colon caused by the bacteria clostridium difficile, causing diarrhea) isolation with active diarrhea, and in yellow zone (area for newly admitted residents with incomplete or unknown COVID-19 vaccination status) room without a gown, face shield, N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of infectious particles in the air) Both FM1 and FM 2 stated they were not instructed which personal protective equipment (PPE) was required and handwashing protocol, to stop the spread of infections, when visiting. During an observation from 12/13/2021 to 12/22/2021, at least four Staff (CNA4, CNA10, CNA9, LVN 13) did not wear the required PPE in the C-diff room, and in the yellow zone (rooms with residents that were symptomatic, or may have been exposed to Covid-19) rooms, did not wash their hands in between resident care for Resident 170, Resident 68, 93, 121, 171, 319 and 321. During an interview on 12/14/2021 at 9:06 a.m., the infection preventionist (IP) confirmed visitors should be educated and made aware they must follow the isolation precautions. IP stated contact isolation is used for C-Diff infections which is, wearing a gown, and gloves and washing hands in between resident care, when any staff or family member came in contact with a resident, without the required PPE and failed to perform, handwashing, the infection can spread, and to anybody 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	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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/14/2021 at 9:08 a.m., IP verified an N95 respirator, face shield, gown and gloves were required PPE when entering yellow zone, and failing to wear this PPE was an infection control issues that put the residents at risk for getting infected for any virus or bacteria and could potentially cause transmission of communicable diseases and infections. During an interview on 12/15/21 at 2:52 p.m., IP stated she provided education to her staff that proper hand-hygiene was required before putting on or taking off PPE and before and after touching a resident. IP stated hand washing with soap and water was required if coming into contact with bowel movements because of possible contamination when going from dirty area to clean area. During a concurrent observation and interview on 12/13/2021 at 11:13 a.m., Housekeeper 1 (HK 1) was observed cleaning a yellowish brown substance (potentially body fluids) on the floor using bleach disinfectant wipes and immediately wiped it with a dry cloth towel and did not follow the manufacturer recommended contact time of 3 minutes and to pre clean prior to disinfecting. HK1 read the manufacturer recommended contact time on the Clorox Bleach container and stated according to the instruction on the bottle, contact time should have been 3 minutes. HK1 admitted he normally disinfected with 10-30 seconds contact time because he has a lot of things to do. During an interview on 12/22/21 at 10:21 a.m. with the Administrator (ADM), acknowledged the facility did not identify staff and visitors were not following infection prevention policies to prevent the spread of communicable disease. ADM stated the IP and DON and himself were trying their best to provide in-services but the full-time DSD was on maternity leave and the assistant DSD covering for the DSD was only working part time and did not to come to facility regularly which might have contributed to the lapse in infection control education of staff and visitors. A record review of Facility Assessment form dated 10/27/2021, indicated all personnel will be trained on infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. 1b. facility failed to investigate a resident-to-staff altercation for 1 of 2 residents (Resident 9) after Health Facilities Evaluator Nurse (HFEN 1) had made the Administrator aware on 12/14/2021 at 12:44 p.m., Resident 9 reported an allegation of abuse and reported that on 11/28/2021 at 2:00 a.m. CNA 3 was involved in a fist fight with Resident 9. . During an interview and concurrent record review of investigation report for the allegation of abuse for Resident 9 on 12/21/21, at 12:44 a.m., ADM was unable to provide documentation and stated he had not initiated an investigation. ADM admitted he failed to report the abuse to Department and could not provide reason why the abuse was not reported and investigated but he should have initiated an investigation immediately when HFEN 1 informed him of the allegation of abuse. ADM stated if he had investigated as soon as he was made aware and dug deeper, he would have found out who the staff was and suspended her to keep the resident safe and prevent possible retaliation from staff. (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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Facility Assessment form dated 10/27/2021, indicated that Staff training/education and competencies topic will include abuse, neglect and exploitation training that at a minimum educates staff on activities that constitutes abuse, neglect, exploitation and procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident abuse prevention. 2. During a concurrent record review of nursing assignment sheets and census (number of residents in the facility) in the skilled-nursing facility (SNF) department for random dates with Assistant Staff Developer (ASD) on 12/21/at 10:00 a.m., ASD stated they were short staffed on the following days: a. 11/7/21, 4 CNAs, 2 LVNs, 1 RN assigned to 100 residents for 11:00 p.m. to 7:00 a.m. shift b. 11/13/21, 4 CNAs, 2 LVNs, 1 RN assigned to 105 residents for 11:00 p.m. to 7:00 a.m. shift c. 11/25/21, 4 CNAs, 2 LVNs, 1 RN assigned to 107 residents for 11:00 p.m. to 7:00 a.m. shift d. 12/16/21, 5 CNAs, 2 LVNs, 1 RN assigned to 104 residents, but 1 CNA called off for 11:00 p.m. to 7:00 a.m. shift e. 12/18/21, 4 CNAs, 3 LVNs, 1 RN assigned to 101 residents for 3:00 p.m. to 11:00 p.m. shift 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 ADM that she did not have adequate staffing, but they were not able to provide additional staff. ASD verified, for a census of 103 they should have 6 CNA at night shift and assigned to maximum of 16 to 21 residents but sometimes they have 26 residents each CNA and that was a lot for 1 CNA. ASD stated they need to have adequate staff for safety of residents, CNAs were tired, and they can get hurt if they were tired and we are going to lose staff if we were always short staff. During an interview on 12/21/at 11:30 a.m., DON stated he was aware that there were days some staff called in sick but unable to find replacement. DON stated they tried to call other staff to come in to work but no one was available but did not try to reach out to sister company, call registry nor reached out to any agency. DON stated they do not have registry and only tried to work with the staff they have. During a concurrent interview and record review of Facility Assessment form dated 10/27/2021, DON confirmed records indicated the general staffing plan to ensure the facility meets the needs of the residents at any given time should be 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. During a concurrent interview and record review of Census and Nursing Hours per Patient Day ([NHPPD] form indicating projected daily nursing hours) for random nursing hours with Director of Nursing (DON) on 12/22/21 at 11:02 a.m., DON stated the NHPPD indicated they were not meeting the required 3.5 nursing hours on the following days because they were short staffed: (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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 11/13/21 final NHPPD was 2.92 b. On 11/25/21 final NHPPD was 2.85 c. On 12/16/21 final NHPPD was 2.52 d. On 12/18/21 final NHPPD was 2.69 DON stated it was important to ensure they meet the required 3.5 NHPPD to follow to meet the overall needs of the residents, and to follow regulations. A record review of Facility Assessment form dated 10/27/2021 indicated NHPPD for SNF=3.5x hours per resident days indicating a) total number of license nurse staff hours per resident per day, b) RN hours per resident per day) LVN hours per resident per day, d) certified nursing assistant hours per day, e) physical therapy staff hours per resident per day. 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. During an interview on 12/22/2021, at 10:50 a.m., ADM stated their process when short staffed was to ask staff to stay over, call off duty staff, and stated they have a contract with registry who can be reached 24 hours a day, 7 days a week. ADM stated he was not aware of the staffing shortage and if he was informed, he would have called registry, used Reddinet a tool that maybe used by the facility to communicate situational information to the county or to MHOAC [(Medical and Health Operational Area Coordinator) Local Emergency Medical Services agency] and report facility status. During a review of the facility's COVID-19 Mitigation Plan [(MP) a plan to reduce the spread of the COVID-19 virus), undated, the MP indicated it is the policy of the facility to maximize the staff availability and utilize these approved staffing registries if they were unable to cover staffing needs during an emergency. If this strategy does not meet the facility's needs, facility may request additional staff through Medical Health operational Area Coordinator program. 3. During an observation on 12/14/2021, at 10:30 a.m., two black trash cans and one gray water basin with water was observed on the floor by the entrance door towards the back of the dining room (also used for activities). The ceiling was observed to have a crack line approximately three (3) feet long with water dripping from ceiling during the Resident Council Meeting, which was attended by 13 residents. This deficient practice can potentially cause, structural damage including ceiling collapse, electrical outage, electrocution, and damage of medical records. A record review of Facility Assessment form dated 10/27/2021, indicated Maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. (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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Facility Assessment form dated 10/27/2021, indicated nursing facility will conduct, document, and annually review a facility wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including segments with third parties, health information technology resources and systems, a facility based and community-based risk assessment, and other information that you may choose.

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

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42243 Based on observation, interview, and record review the facility's Quality Assessment and Assurance ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed identify facility and resident care issues, develop and implement appropriate plans of action: 1. To ensure QAA/QAPI committee systematically implemented and evaluated measures to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections: These failures placed all the residents, staff, and the community at higher risk for cross contamination, and increased spread of clostridium difficile ([C-diff] Inflammation of the colon caused by the bacteria Clostridium difficile) and COVID-19 ([a highly contagious infection, caused by a corona virus that can easily spread from person to person]) infection in the facility and the community. 2. To ensure QAA/QAPI committee promptly implemented measures to correct problems with lack of sufficient competent staff to assure residents' care and safety needs were met. This deficient practice had the potential to affect all 122 residents who resided in the facility, and residents not receiving the treatments necessary to meet their highest potential and well-being. 3. To ensure QAA/QAPI committee provide safe, functional, sanitary, and comfortable environment for 122 residents, staff, and visitors by not maintaining the facility's roof, resulting in multiple water leaks from the ceiling in the dining room (also used for activities) and nurses' station. This deficient practice can potentially cause, structural damage including ceiling collapse, electrical outage, electrocution, and damage of medical records. 4. To ensure the QAA/QAPI committee implemented the facility's written abuse policy and procedure and ensured the alleged perpetrator CNA3 did not have continued access to one of 2 residents (Resident 9) by failing to report and investigate properly the alleged abuse. These deficient practices resulted in physical and psychological harm to Resident 9 when facility failed to follow-up on the abuse incidents to ensure Resident 9 felt safe and secure. Findings: Cross reference to F880 (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

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. During an observation and interview from 12/13/2021 to 12/22/2021, at least two Family member (FM1 and FM2) were observed not following infection control practices for a resident (Resident 170) on clostridium difficile ([C-diff] inflammation of the colon caused by the bacteria clostridium difficile) isolation with active diarrhea, and in yellow zone (area for newly admitted residents with incomplete or unknown COVID-19 vaccination status) room without a gown, face shield, N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of infectious particles in the air) . Both FM1 and FM 2 stated they were not instructed what were the required PPE and handwashing protocol when visiting. During an observation from 12/13/2021 to 12/22/2021, at least 4 Staff (CNA4, CNA10, CNA9, LVN 13) did not wear the required PPE in Cdiff room and in yellow zone room, did not wash their hands in between resident care for Resident 170, Resident 68, 93, 121, 171, 319 and 321. During an interview on 12/14/2021 at 09:06 a.m., the infection preventionist (IP) stated that visitors should be informed and made aware they must follow the isolation precaution. IP stated that for C-Diff contact isolation, it requires gown, gloves and mask and washing hands in between care, when any staff or family member will be in contact with the resident not wearing required PPE and not performing handwashing can spread, and cross contaminate with anybody in the facility. During an interview on 12/14/2021 at 09:08 a.m., IP stated N95, face shield, gown and gloves were required PPE when entering yellow zone and not wearing PPE was an infection control issues that will put the resident at risk from getting infected for any virus or bacteria and can potentially cause transmission of communicable diseases and infections. During an interview on 12/15/21 at 2:52 p.m., IP stated she provided education to her staff on proper handwashing and hand-hygiene was required before putting on or taking off PPE and before and after touching the resident. IP stated hand washing with soap and water was required if touching bowel movement because of possible contamination when going from dirty area to clean area. During a concurrent observation and interview on 12/13/2021 at 11:13 a.m., Housekeeper 1 (HK 1) was observed cleaning yellowish brown substance (potentially body fluids) on the floor using bleach disinfectant wipes and immediately wiped it with dry cloth towel and did not follow the manufacturer recommended contact time of 3 minutes and to pre clean prior to disinfecting. HK1 stated no additional steps was needed when cleaning potential body fluids. HK1 read the manufacturer recommended contact time on the bleach container and stated according to the instruction on the bottle, contact time should be 3 minutes. HK1 admitted he normally disinfect with 10-30 seconds contact time because he has a lot of things to do. During a review of the manufacturer label for Clorox Bleach wipe, indicated to clean and disinfect visibly soiled surfaces, pre cleaning is required prior to disinfecting and contact time is 3 minutes. During a concurrent interview and review of the QAPI minutes on 12/22/21 at 10:21 a.m. with the Administrator, the QAPI minutes indicated the facility addressed COVID-19 concerns monthly but despite monthly monitoring the facility did not identify staff and visitors were not following infection prevention policies to prevent the spread of communicable disease. (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

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's P/P titled Quality Assurance and Performance Improvement (QAPI) QAPI Plan, undated, indicated the scope of the QAPI program encompasses all segments of facility, including House Keeping Services, will provide and ensure that all health, sanitation, and OSHA [(Occupational Safety and Health Administration) is a large regulatory agency of the United States Department of Labor that originally had federal visitorial powers to inspect and examine workplaces] requirements are met through regular cleaning, disinfection, and sanitation of all aspects of the building. Cross reference to F725 b. During a concurrent record review of nursing assignment sheets and census (number of residents in the facility) in the skilled-nursing facility (SNF) department for random dates with Assistant Staff Developer (ASD) on 12/21/at 10:00 a.m., ASD stated they were short staffed on the following days: a. 11/7/21, 4 CNAs, 2 LVNs, 1 RN assigned to 100 residents for 11:00 p.m. to 7:00 a.m. shift b. 11/13/21, 4 CNAs, 2 LVNs, 1 RN assigned to 105 residents for 11:00 p.m. to 7:00 a.m. shift c. 11/25/21, 4 CNAs, 2 LVNs, 1 RN assigned to 107 residents for 11:00 p.m. to 7:00 a.m. shift d. 12/16/21, 5 CNAs, 2 LVNs, 1 RN assigned to 104 residents, but 1 CNA called off for 11:00 p.m. to 7:00 a.m. shift e. 12/18/21, 4 CNAs, 3 LVNs, 1 RN assigned to 101 residents for 3:00 p.m. to 11:00 p.m. shift 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) that 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. ASD stated for census of 103 they should have 6 CNA at night shift and assigned to maximum of 16 to 21 residents but sometimes they have 26 residents each CNA and that was a lot for 1 CNA. ASD stated they need to have adequate staff for safety of residents, CNAs were tired, and they can get hurt if they were tired and we are going to lose staff if we were always short staff. During an interview on 12/21/at 11:30 a.m., DON stated he was aware that there were days some staff called in sick but unable to find replacement. DON stated they tried to call other staff to come in to work but no one was available but did not try to reach out to sister company, call registry nor reached out to any agency. DON stated they do not have registry and only tried 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 random nursing hours with Director of Nursing (DON) on 12/22/21 at 11:02 a.m., DON stated the NHPPD indicated they were not meeting the required 3.5 nursing hours on the following day because they were short staffed: a. On 11/13/21 final NHPPD was 2.92 (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

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 11/25/21 final NHPPD was 2.85 c. On 12/16/21 final NHPPD was 2.52 d. On 12/18/21 final NHPPD was 2.69 DON stated it was important to ensure they meet the required 3.5 NHPPD to follow the regulations and to meet the overall needs of the residents. During a concurrent interview and review of the QAPI minutes on 12/22/2021 at 10:50 a.m., with ADM, ADM stated they did not discussed concerns with staffing in their QAPI meeting and stated their process when short staffed was to ask staff to stay over, call off duty staff, and stated they have a contract with registry who can be reached 24 hours a day, 7 days a week. ADM stated he was not aware of the staffing shortage and if he was informed, he could have called registry, use Reddinet a tool that maybe used by the facility to communicate situational information to the county or to MHOAC [(Medical and Health Operational Area Coordinator) Local Emergency Medical Services agency] and report facility status. During a review of the facility's COVID-19 Mitigation Plan [(MP) a plan to reduce the spread of the COVID-19 virus), undated, the MP indicated it is the policy of the facility to maximize the staff availability and utilize these approved staffing registries if they were unable to cover staffing needs during an emergency. If this strategy does not meet the facility's needs, facility may request additional staff through Medical Health operational Area Coordinator program. 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. Cross reference to F921 c. The QAA/QAPI committee failed to ensure to provide safe, functional, sanitary, and comfortable environment for 122 residents, staff, and visitors by not maintaining the facility's roof, resulting in multiple water leakage from the ceiling in the dining room and nurses' station. During a QAPI interview on 12/22/2021 at 10:50 a.m. with ADM, ADM stated they had not identified that roof needed repair and did not expect the heavy rain will cause leak in the ceiling and this can potentially cause, structural damage including ceiling collapse, electrical outage, electrocution, and damage of medical records. According to the facility's P/P titled Quality Assurance and Performance Improvement (QAPI) QAPI Plan, undated, indicated the scope of the QAPI program encompasses all segments of facility, including resident/family feedback, staff satisfaction, individualized resident care plans, information technology, facility maintenance plan and QAPI. Maintenance/ Engineering: Facility will provide comprehensive building safety, repairs, and inspections to ensure all aspects of safety are enforced, assuring the safety and well-being for each resident, visitor, and staff who enters the building. Cross Reference to F607/F610 (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

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. The QAA /QAPI committee failed to monitor the provision of care to ensure the staff adhered to facility's abuse policy and procedure and ensured the alleged perpetrator CNA3 did not have continued access to one of 2 residents (Resident 9) by failing to report and investigate properly the alleged abused. During a QAPI interview on 12/22/2021 at 10:50 a.m. with ADM, ADM stated that all allegations of abuse should be reported and investigated. The Administrator acknowledged QAPI was a tool to identify and monitor issues and find a solution, but they had not identified some of the facility's concerns and were not discussed during QAPI meeting. According to the facility's P/P titled Quality Assurance and Performance Improvement (QAPI) Plan, undated, indicated the Quality Assurance (QA) committee will review data and input monthly to look for potential topics for PIP [(Performance Improvement Projects,)] will monitor and analyze data and review feedback and input from residents, staff, families, volunteers, and stakeholders. QA will look at issues, concerns, and areas that need improvement as well as areas that will improve quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider: High risk, high volume, or problem prone areas that affect health outcomes, quality of care and services and areas that affect staff.

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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on observation, interview and record review, the facility failed to implement acceptable infection control practices to prevent the spread and transmission of communicable diseases and for the prevention of coronavirus (COVID-19) and Clostridium Difficile ([C-diff] Inflammation of the colon caused by the bacteria Clostridium difficile. The facility failed to: 1. Ensure Resident 170's family member (FM) was educated and made aware of the facility's infection control practices for contact isolation due to clostridium difficile with active diarrhea. FM was observed to do the following: a. FM was observed not wearing gloves while feeding Resident 170. b. FM was observed bringing Resident 170's bedside table to the hallway outside of the room without disinfecting it and without performing hand hygiene (cleaning your hands can prevent the spread of germs [washing hands]). c. FM returned to the room with the previous gown and did not perform hand hygiene. d. Ensure Certified Nursing Assistant (CNA 4) wore gloves as indicated when returning the bedside table to the room of Resident 170, who was on contact isolation. 2. Ensure Certified Nursing Assistant (CNA 4) wore a Face shield while in the room of Resident 171, who was in the yellow zone (zone for residents who are mixed quarantine or symptomatic) to prevent transmission of COVID-19. 3. Ensure Certified Nursing Assistant (CNA 10) wore gloves and a gown while in a yellow zone room of Resident 319. 4. Ensure CNA 10 washed her hands between changing gloves and after completing peri care for Resident 321. 5. Ensure Housekeeper 1 (HK 1) followed the manufacturers recommended contact time to wait three minutes when using Disinfectant A wipes before wiping and drying up body fluids. HK 1 covered the body fluid and waited 10-30 seconds instead of three minutes before he wiped and dried the area. These failures placed all residents (122 total), staff, visitors, and the community at a high risk for cross contamination, and increased spread of C-Diff and COVID-19 (a potentially severe respiratory illness caused by a coronavirus and characterized by fever, coughing, and shortness of breath) infection. On 12/16/2021, at 1:06 p.m., the 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 to a resident) related to the failure to implement acceptable infection control practices was called in the presence of the Administrator. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/21/21, at 1:58 p.m., the IJ situation was removed in the presence of the Administrator after implementation of the acceptable POA was verified onsite through observation, interview, and record review. Findings: 1. A review of Resident 170's Face Sheet (admission record) indicated Resident 170 was admitted to the facility on [DATE] with diagnoses including C-Diff, major depressive disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts), acute respiratory failure with hypoxia (not enough oxygen in your blood, but your levels of carbon dioxide are close to normal) anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 170's Minimum Data Set (MDS- a standardized assessment and care-screening tool) dated 12/22/21, indicated the resident had severely impaired cognitive skills for daily decision making and was totally dependent on staff for bed mobility, eating, locomotion off and on unit, transfers, dressing, toilet use, personal hygiene, and bathing. On 12/13/2021 at 12:29 p.m., Resident 170's FM was observed feeding Resident 170 in Resident 170's room without wearing gloves. FM proceeded to bring Resident 170's bedside table to the hallway outside of Resident 170's room without having table disinfected. At the same time, FM was observed not performing a hand hygiene. After FM was observed moving Resident 170's bedside table to the hallway, FM returned to Resident 170's room wearing the same gown and again did not perform a hand hygiene. Few minutes later, a Certified Nursing Assistant (CNA 4) was observed returning Resident 170's bedside table back to the resident's room without wearing gloves. Concurrently during an interview, Resident 170's FM stated that none of the facility's staff instructed her regarding proper use of required personal protective equipment (PPE) for Resident 170 contact isolation precaution due to C-diff. During an interview on 12/14/2021 at 9:06 a.m., the facility's infection preventionist ([IP] nurse in charge of infection prevention at the facility), stated when a family member wished to feed a resident, who is on isolation, the family member must be instructed and made aware that they must follow all isolation precautions and use of PPE. IP further stated when a resident is on contact isolation for C-Diff, staff and family members are required to wear a gown and gloves, and to wash their hands in between care. IP stated when any staff or family member, who has been in contact with the resident without the required PPE, does not wash their hands and goes outside the resident's room without removing their used gown, it is an infection control concern. It is very clear, when staff or family members do not follow necessary infection control practices there is a high risk for them to spread infection to other staff, residents and visitors in the facility. IP stated FM should have work gown and gloves and washed their hands between care of Resident 170. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/14/2021 at 9:28 a.m., the Registered Nurse supervisor (RN 1) stated that any staff or family member who provides care or visits with a resident on contact isolation for C-diff, must wear the required PPE before caring for a resident, remove the used gown and gloves, and wash their hands before leaving a resident's room, and put on clean PPE before going back to a resident's room. RN1 stated when staff or family members do not follow a required infection control practice, it becomes an infection control issue and has the potential for cross contamination and spread of infection to staff, resident, and their family members. RN 1 further stated when visitor's sign in, the receptionist must inform the charge nurse (CN) to educate the visitor regarding the required PPE for contact isolation precautions. On 12/14/2021 at 11:56 a.m., Resident 170's FM was observed at the resident's bedside interacting with the resident without wearing gloves. During an interview on 12/14/2021 at 1:10 p.m., the Licensed Vocational Nurse (LVN 3) stated that Resident 170's FM visits the facility daily and the FM must follow the required PPE requirements before going to see the resident due to contact isolation precautions related to C-diff. During an interview on 12/14/2021 at 1:18 p.m., the RN 1 supervisor stated that it is everybody's job to remind the resident's FM to follow the required isolation precautions when entering the isolation room. A review of the facility's revised policy and procedure dated October 2018 and titled, Clostridium Difficile indicated that measures are to be taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are to be taken while caring for residents with C. difficile to prevent transmission to other residents. Frequent hand washing should be performed with soap and water by staff and residents. When caring for residents with C-diff, staff are to maintain vigilant hand hygiene. Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on contact precautions. Hand washing with soap and water is superior to antimicrobial hand-rub (ABHR) for the mechanical removal of C. difficile spores from hand. A review of facility's policy and procedure titled Visitation-Infection Control During COVID 19, revised 11/2021, indicated the facility shall establish appropriate guidelines for visitors to try and prevent the transmission of communicable diseases. The top priority at this point with COVID 19 is to prevent the virus from entering the facility. All visitors shall be screened upon entry and shall be required to wear face coverings and adhere to the guidelines of the facility. Each visitor must wear a face covering upon entry and at all times within the facility and must wear other PPE as appropriate while in the patient's room. 2. A review of Resident 171's Face Sheet (admission record) indicated Resident 171 was admitted to the facility on [DATE], with diagnoses including pneumonia (Infection that inflames air sacs in one or both lungs, which may fill with fluid), hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), atherosclerotic heart disease of native coronary artery without angina pectoris (a hardening and narrowing of your arteries caused by cholesterol plaques lining the artery over time). (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the Minimum Data Set (MDS- a standardized assessment and care-screening tool) dated 12/20/21, indicated Resident 171 had an intact cognitive skill for daily decision making and required assistance with personal hygiene, toileting, and mobility. During an observation on 12/13/2021 at 3:21 p.m., CNA 4 was observed providing care to Resident 171 (a resident who was in the yellow zone who may be suspected of having COVID-19) while wearing a regular mask (not a N95 respiratory, as required for all staff providing care in the yellow zone) without out a face shield (eye protection is required for all staff who provide care to residents in the yellow zone. During an interview on 12/13/2021 at 3:23 p.m., CNA 4 stated that she should wear all required PPE when attending a resident while inside the isolation room, including a N95 and a face shield. CNA 4 stated that she does not have an excuse for not wearing all the required PPE. CNA 4 admitted that it was an infection control issue that can lead to cross contamination of staff and all the residents that she will encounter. During an interview on 12/14/2021 at 9:08 a.m., the IP stated that based on what is posted outside the resident room for isolation precautions, an N95, face shield, gown and gloves were required to provide care for Resident 171, who was on contact and respiratory droplets isolation. If one of the required PPE is not worn while providing care to the resident it becomes an infection control issue that can lead to cross contamination and places the resident at risk for getting infected. During an observation on 12/16/21 at 3:15 pm, a family member of Resident 171 was observed in the resident's room without a gown, face shield, and a N95 mask. At the same time there was a Respiratory Therapist 3 (RT 3) present and was providing respiratory care. RT 3 did not instruct the Family member about observing isolation precautions by wearing necessary PPE and of the potential risk for spread of infection if not followed the requirement for PPE. On 12/16/21 at 3:15 pm, during an interview, Resident 171's family member stated the facility staff did not instruct her to wash her hands, or to wear gloves and a face shield, but she was only told to bring a N95 mask or wear a gown when visiting. on 12/16/21 at 3:44 pm, during an interview, Respiratory Therapist 3 (RT) stated that he did not instruct the visitor about observing isolation precautions and of the potential for infection spread if isolation precautions were not practiced in the facility. 3. On 12/13/2021 at 11:04 a.m. inside the room for three residents, Resident 10, Resident 38, and Resident 55 there was a yellowish-brown semi-liquid substance observed on the floor. This room was on the green zone (zone for residents who do not have COVID-19). Concurrently, during an interview, CNA 1 stated that it could be apple sauce, but it could also be feces or body fluids. CNA 1 stated she would ask the housekeeper to clean it. During a concurrent observation and interview on 12/13/2021 at 11:11 a.m., LVN 5 stated the yellowish-brown substance on the floor in the room of Resident 10, Resident 38, and Resident 55 could be applesauce, feces, or could be body fluids and will have housekeeper to clean it. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview on 12/13/2021 at 11:13 a.m., Housekeeper (HK1) stated the yellowish brownish substance in the room for Resident 10, Resident 38, and Resident 55, looks like feces. HK1 observed cleaning the yellowish-brown substance on the floor by using Disinfectant A wipes and immediately wiping it with a dry cloth towel. During an interview on 12/13/2021 at 11:25 a.m., HK1 stated he cleaned the potential body fluids by squeezing the disinfectant wipes so bleach will cover the potential body fluids then immediately wiped it using the same disinfectant wipes with contact time of 10 to 30 seconds and then he dried it with a dry rag. HK1 stated no additional steps were needed when cleaning potential body fluids. HK1 read the manufacturer recommended contact time on the bleach container and stated, according to the instruction on the bottle, contact time should be three (3) minutes. HK1 stated he normally disinfect with 10-30 seconds contact time because he has a lot of things to do. During an interview on 12/15/2021 at 12:15 p.m., Maintenance Supervisor (MS) stated the proper way to clean body fluids was first to remove the feces, clean the surface, then disinfect. MS stated when using Disinfectant A wipes the contact time should be three (3) minutes. During an interview on 12/15/2021 at 2:53 p.m., IP stated to clean potential body fluids or feces on the floor, the housekeeper needed to clean the feces first, then disinfect and follow manufacture recommended contact time. IP stated Disinfectant A's (disinfecting wipes) manufacturer recommended contact time was three minutes. IP stated not cleaning and disinfecting potential body fluids or contaminated surfaces can potentially infect residents, staff, and other visitors, and can cause illness, hospitalization , or death. A review of the facility's revised facility's policy and procedure dated January 2012 and titled, Cleaning Spills or Splashes of Blood or Body fluids, indicated spills or splashes of blood or other body fluids must be cleaned and the spill or splash area decontaminated as soon as practical. A review of the manufacturer label for Disinfectant A, indicated to clean and disinfect visibly soiled surfaces; pre-cleaning was required prior to disinfecting and contact time was 3 minutes. 4. On 12/13/21, at 12:22 p.m., a Certified Nursing Assistant (CNA 10) was observed in yellow zone room (area for newly admitted residents with incomplete or unknown COVID-19 [a highly contagious infection, caused by a corona virus that can easily spread from person to person] vaccination status), setting up Resident 319's lunch tray. CNA 10 was observed wearing a personal protective equipment ([PPE] equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses,), a N95 mask (PPE worn on the face, covers at least the nose and mouth, and is used to filter out at least 95% of airborne (infection virus-containing smaller particles that can remain suspended in the air over long distances) and a face shield, but was not wearing gloves or gown. CNA 10 was observed leaving Resident 319's room without performing hand-hygiene and walking across the hallway holding a plate cover and placing it on the food delivery cart. CNA 10 observed to performed hand-hygiene with ABHR near the food cart. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/13/21, at 12:30 p.m. CNA 10 stated it is required to wear a gown, a N95 mask, goggles or face shield, and gloves, and to sanitize hands before and after delivering the food tray in the yellow zone. CNA 10 stated she forgot to wear a gown and gloves when was in the yellow zone room. CNA 10 stated without wearing full PPE, there is a potential to spread an infection. CNA 10 confirmed that she must perform hand hygiene after delivering the meal trays for all residents but did not perform the hand hygiene after delivering Resident 319's meal tray. During an interview on 12/14/21, at 11:55 a.m. the IP stated Resident 319 was in room in the yellow zone for isolation because Resident 319 has not completed her full dose of the COVID-19 vaccine. IP stated Resident 319 received her second dose of the COVID-19 vaccine upon admission to the facility and has not completed her 14 days of quarantine in the yellow zone room. A review of Resident 319's admission record (Face sheet), indicated the resident was admitted to the facility on [DATE], with diagnoses including hyperlipidemia ([HLD] a condition that causes the levels of certain bad fats, or lipids, to be too high in the blood), major depressive disorder ([MDD] a common but serious mood disorder that can cause severe symptoms affecting how you feel, think, and handle daily activities, such as sleeping, eating, or working), hypertension ([HTN] a condition present when blood flows through the blood vessels with a force greater than normal), and urinary tract infection ([UTI] an infection of some part of the urinary tract). A review of the Minimum Data Set ([MDS], a standardized assessment and care-screening tool), dated 12/15/21, indicated Resident 319 moderately impaired cognitive skills for daily decision making and required extensive assistance from staff with bed mobility, dressing, and toileting and was totally dependent on staff with bathing. A review of Resident 319's COVID-19 vaccination record card, indicated the resident received her first dose of the Pfizer vaccine on 7/27/21, and the second dose on 12/10/21, while residing at the facility. During an interview on 12/15/21, at 3:33 p.m. the IP stated she provides education to her staff on PPE requirements and hand hygiene. IP stated staff going into the rooms on the yellow zone were required to perform hand hygiene prior to donning (putting on) PPE and were required to wear gloves, gown, N95 mask, and eye protection with googles or a face shield. When leaving the room, staff required to perform hand hygiene after removing PPE. IP stated if proper PPE and hand hygiene is not done, there is a risk to spread infection. A review of the facility's COVID-19 Mitigation Plan indicated the residents assigned in a yellow zone room will be treated with contact and droplets isolation precautions. When caring for patients with confirmed or suspected COVID-19, face shield or goggles, N95 mask or higher respirator, gloves, and isolation gown were to be used. A review of the facility's policy, Isolation - Categories of Transmission-Based Precautions, revised 10/2018, indicated staff caring for residents on contact precautions will wear gloves and gown upon entering the room. Staff caring for residents on droplet precautions will wear masks, gloves, a gown and googles should be worn if there is risk of spraying respiratory secretions. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's policy, Handwashing/Hand Hygiene, revised 8/2019, indicated an alcohol-based hand rub containing at least 62% alcohol should be used or, alternatively soap (antimicrobial or non-antimicrobial) and water should be used before and after direct contact with residents; after contact with objects in the immediate vicinity of the resident; after removing gloves; before and after entering isolation precaution setting; before and after eating or handling food; before and after assisting a resident with meals. Hand hygiene is the final step after removing and disposing of personal protective equipment. 5. During a concurrent observation and interview, on 12/13/21, at 10:44 a.m., with CNA 10, CNA 10 was observed performing incontinence (the loss of bowel and/or bladder control) care to Resident 321. CNA 10 was observed wearing a N95 face mask and a face shield and putting gloves on after performing hand hygiene with ABHR. CNA 10 stated Resident 321 had a bowel movement. CNA 10 was observed wiping Resident 321's bottom with a pad, then cleaning the residents bottom with soap and water, and with a new towel patting dry the resident's bottom. CNA 10 then removed used gloves and put on a new pair of gloves to clean the resident's private parts with a clean towel without performing a hand hygiene between changing gloves. CNA 10 was observed to use a new towel to pat dry the resident's private area and then removing her gloves. CNA 10 was observed not performing hand hygiene with hand sanitizer or wash her hands with soap and water after removing gloves. Concurrently, during an interview, CNA 10 stated she forgot to get a new pad to place under the Resident 321. CAN 10 opened Resident 321's closet, went outside of the room to get a new incontinent pad from the clean linen cart in the hallway. Then CNA 10 returned to the room and washed her hands with soap and water, put on a new pair of gloves to complete the resident's care. She then removed her gloves and washed her hands with soap and water after finishing care. CNA 10 stated she usually changed gloves during care and would wash her hands after completing care. During an interview on 12/13/21, at 11:00 a.m., CNA 10 stated when performing patient care, one should gather equipment that will be used during care and wash hands prior to performing care. CNA 10 stated she was trained to change gloves if they become soiled during care, and to clean with hand sanitizer in between changing gloves, and to wash hands when done with care. During an interview on 12/15/21, at 2:52 p.m., the IP stated she provides education to her staff on proper handwashing. IP stated hand-hygiene was required before putting on or taking off PPE and before and after coming in contact with the resident. IP stated hand washing with soap and water was required if touching bowel movement because of possible contamination when going from dirty area to clean area. A review of Resident 321's Face sheet indicated the resident was admitted to the facility on [DATE], with diagnoses including UTI, weakness, heart failure (a condition in which the heart has trouble pumping blood thought the body), type 2 diabetes (abnormal blood sugar), Parkinson's disease (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), , hyperlipidemia (HLD), and atrial fibrillation (rapid, irregular beating of the heart). A review of Resident 321's MDS, dated [DATE], indicated the resident had severely impaired cognitive skills for daily decision making and required extensive assistance from staff with bed mobility, dressing, and toileting and required a total dependence from staff in bathing. (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

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's policy, titled Handwashing/Hand Hygiene, revised August 2019, indicated to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after direct contact with residents; after contact with objects in the immediate vicinity of the resident; after removing gloves; before moving from a contaminated body site to a clean body site during resident care. The use of gloves does not replace hand washing/hand hygiene. Integrating glove use along with routine hand hygiene as it is recognized as the best practice for preventing healthcare-associated infections.

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

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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42243 Based on observation, interview and record review, facility failed to provide safe, functional, sanitary, and comfortable environment for 122 of 122 residents, staff, and visitors, by not maintaining the facility's roof, resulting in multiple water leakage from the ceiling in the dining room (also used for activities) and nurses' station. This deficient practice can potentially cause, structural damage including ceiling collapse, electrical outage, electrocution, and damage of medical records. During an annual recertification survey on 12/14/2021, at 6:05 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 water leaking from the ceiling in the dining room and nurses ' station. During an interview on 12/15/2021, at 4:25 p.m., the ADM was informed that the IJ was lifted after implementation of the acceptable plan of action ([POA], interventions to correct the deficient practice) was verified while on onsite via observation, interview, and record review. Findings: Facility census: 122 a. During an observation on 12/14/2021, at 10:30 a.m., during the Resident Council Meeting, two black trash cans and one gray water basin were observed on the floor by the entrance door towards the back of the dining room (also used for activities) with water in the containers. The ceiling was observed to have a crack line approximately three (3) feet long with water dripping from ceiling during the Resident Council Meeting, which was attended by 13 residents. During an observation on 12/14/2021, at 12:30 p.m., during a dining observation, there were 20 residents eating in the dining room. Water was observed dripping from the ceiling into the two black trash cans and gray water basin by the entrance door towards the back of the dining room. There was no cautionary signage observed to indicate the possibility of a wet floor. During a concurrent observation and interview on 12/14/2021, at 12:35 p.m., with Licensed Vocational Nurse 5 (LVN 5), in the dining/activity room, water was observed dripping from the ceiling into the two black trash cans and the gray water basin by the entrance door towards the back of the dining room. LVN 5 stated it was raining hard today (12/14/21) and there was water dripping from the ceiling and the black trash cans and the gray water basin were used to catch the water from the ceiling. LVN 5 stated there were 20 residents inside the dining area despite water leaking from the ceiling and residents were positioned to avoid areas where the water was dripping from the ceiling. (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

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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 12/14/2021, at 2:21 p.m., with the Activities Assistant (AA1), AA1 stated it was raining hard today (12/14/21) and at 9:00 a.m. she observed water leaking from the ceiling inside the dining room, there was a water basin on the floor to catch water. AA1 stated the floor was wet and noticed there was more water leaking from the right side of the ceiling and asked Housekeeper 1 (HK1) to bring another bucket to catch the water. AA1 stated the residents did not start entering the back dining area until after 10:00 a.m. to prepare for the Resident Council Meeting. AA1 stated she ensured there were containers to catch the water dripping from the ceiling. AA1 stated she notified Maintenance Supervisor (MS) regarding the water leaking from the ceiling at the back dining area because she was concerned residents who were using the wheelchair could spread the water around and resident who were able to walk in the area might slip and fall. AA1 stated there was no signage placed around the area where water was leaking to indicate the floor was wet. AA1 stated that cautionary signage was important to alert people of a hazard that can cause slip and falls due to a wet floor. During a concurrent observation and interview, on 12/14/2021, at 2:30 p.m. with AA1, nine (9) residents were observed sitting towards the back of the dining room participating in activities. Two black trash cans and a gray water basin filled with water were observed and were initially observed during the Resident Council Meeting at 10:30 a.m. and during the dining observation at 12:30 p.m. AA1 stated the dining area was used at 10:00 a.m. by 13 residents for the Resident Council Meeting, used by 20 residents during lunch, and was currently being used for activities. AA1 stated the dining room was also scheduled for use for dinner later that evening (12/14/21). AA1 stated the staff and residents will continue to use the dining area despite the water leaking from the ceiling. During a concurrent observation and interview, on 12/14/2021, at 2:37 p.m. with MS, MS stated it was raining hard on 12/14/2021 and there was an abrupt water leakage from the ceiling in the dining/ activity room on 12/14/2021 at 6:00 a.m. MS stated there was a crack approximately three feet in length in the ceiling where the water was dripping. MS stated the cause of the crack was unknown. MS stated the facility placed buckets on the floor to prevent water from splashing everywhere but did not believe the water leaking from the ceiling was a potential hazard that could cause residents to slip and fall, get electrocuted, or injured from a ceiling collapse due to water accumulation. MS stated the facility continued to use the back dining room for activities and dining despite the continued water leakage from the ceiling. During an interview on 12/14/2021 at 3:00 p.m. with LVN 5, LVN 5 stated it was raining hard around 6:30 a. m. and when she passed by the dining room, she saw water leaking from ceiling. LVN 5 stated she was concerned that the ceiling might collapse and was scared for herself and the residents. LVN 5 stated the facility's staff continued to allow residents in the dining room for the Resident Council Meeting, dining for lunch, and activities despite water leaking from the ceiling. LVN 5 stated during dining on 12/14/2021, at around 12:00 p.m., she almost tripped on the gray water basin because there was no cautionary signage indicating the floor was wet nor that the gray water basin was on the floor. During an observation on 12/14/2021, at 4:50 p.m. water was observed dripping from the ceiling in the dining room. Water was observed dripping into the two black trash containers and gray water basin while there was one resident (Resident 112) and one staff in the dining area. (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

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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 12/14/21 at 03:23 p.m. with the Activities Director (AD), AD stated there was water dripping from the ceiling in the dining room this morning (could not specify the time) and buckets were placed on the floor to catch the water leaking from the ceiling. AD stated the facility was planning to use the room for dinner tonight (12/14/21) despite the water leaking from the ceiling. AD stated she did not know what could happen if there was accumulation of water in the ceiling. AD stated she did not think of the risks of occupying and using the dining and activities room despite the continued water leakage from the ceiling. AD stated the facility did not consider moving residents out of the dining and activities room to keep them safe from possible environmental hazard. During an interview on 12/14/2021, at 03:45 p.m. with MS, MS stated the roof, ceiling, and structure of the building, has not been assessed or inspected because he could not access the ceiling. MS stated he tried to contact Vendor 1, a third-party vendor, to assess and fix the leak in the roof but there was no response and was still waiting for a call back. During an interview on 12/14/21, at 03:51 p.m., with ADM, ADM stated the facility has not assessed the extent of the water damage caused by the rain because it was actively raining. ADM stated that the facility did not have a plan to address the leaking roof and ceiling. ADM stated the facility was not planning on evacuating or relocating the dining and activities service and will continue to use the dining and activities room despite the active water leak from the ceiling. The ADM could not verbalize whether the dining and activities room was safe to use despite the active water leak from the ceiling. b. During an observation on 12/14/2021, at 12:45 p.m., at the nurses' station (the only nurses' station in the facility), water was observed dripping from the ceiling. Six staff (LVN 5, LVN 8, Certified Nurse Assistant 9 [CNA 9], Registered Nurse 5 [RN 5], Director of Nursing [DON], and the Infection Preventionist [IP]) were present and all 122 resident medical records were observed at the nurses ' station. During an interview on 12/14/2021 at 12:35 p.m., with LVN 5, at the nurses' station, LVN 5 stated that Residents' charts were located at the nursing station and there was a continuous drip of water inside the nursing station. LVN 5 stated she was afraid that ceiling might fall. During an observation on 12/14/2021 at 3:00 p.m., at the nurses' station, water was observed continuously dripping from the ceiling. During a concurrent interview and record review, on 12/14/21, at 4:18 p.m., with ADM, the Emergency Preparedness Plan was reviewed. ADM stated the water leaking in the ceiling and pooled water in the ceiling was a safety hazard that could potentially cause anyone to fall, ceiling might collapse, and if water was leaking directly in the light fixture could cause electrical outage and short-circuit (allows a current to travel along an unintended path) and needed to be addressed right away. ADM stated the facility must close the dining room and secure the medical records until the ceiling was repaired of the water leak to ensure a safe environment where all residents, staff, and medical records are free from environmental hazards. (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

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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of the facility's Policy and Procedure (P/P) titled, Maintenance, dated revised 2009, the P/P indicated Maintenance service shall be provided to all areas of building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Function of maintenance personnel include but not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. The maintenance Director is responsible for maintaining the following records/reports a. Inspection of the building, b. work order request, c. maintenance schedules d. authorize vendor listing, e. Warranties and guarantees. Records shall be maintained in the Maintenance Director's office. Maintenance personnel shall follow established safety regulations to ensure safety and well-being of all concerned.