STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056220	A. Building B. Wing	07/11/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to answer call lights in a timely manner for three out of three sampled residents (Resident 1, 2, and 3). This deficient practice had the potential to cause a negative impact on Resident 1, 2, and 3's health and psychosocial well-being. Findings: 1. A review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of the pubis (bone that forms the lower and anterior part of each side of the hip bone) and fracture of the sacrum (large, triangle-shaped bone in the lower spine that forms part of the pelvis [area of the body below the abdomen that contains the hip bones, bladder, and rectum]). A review of Resident 1's History and Physical (H&P) dated 2/14/2024, indicated Resident 1 had the capacity to understand make medical decisions. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/21/2024, indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 required supervision for eating, oral hygiene, upper body dressing, and personal hygiene. During an interview on 7/10/2024 at 11:55 a.m. with Resident 1, Resident 1 stated when she was admitted to the facility, she was bedridden and it took staff at least 15 minutes to see what she needed. Resident 1 stated when staff came to her room, she asked staff to change her diaper and staff told her she had to wait 15 minutes because they were going on a break. Resident 1 stated it was unacceptable for a resident to have to wait that long to get any assistance. Resident 1 stated it happened on a daily basis to all residents in the facility. 2. A review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including respiratory failure (serious condition that makes it difficult to breathe on your own, lungs can't get enough oxygen into the blood) with hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis) and chronic pulmonary edema (condition where fluid accumulates in lung tissues, causing shortness of breath, wheezing and coughing up blood). (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's H&P dated 5/8/2024, indicated Resident 2 could make needs known but could not make medical decisions. A review of Resident 2's MDS, dated [DATE], indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating, oral hygiene, and upper body dressing and required moderate assistance (helper does less than half the effort) for toileting hygiene, personal hygiene, and lower body dressing. During an interview on 7/10/2024 at 10:59 a.m. with Resident 2, in Resident 2's room, Resident 2 stated staff did not like to answer call lights and when staff did answer call lights, they came into her room with an attitude. Resident 2 stated staff came into her room, asked why she needed help so much, and staff screamed at her. Resident 2 stated she felt staff did not like her. Resident 2 stated her vision was impaired and that was why she needed staff assistance to guide her to the restroom or around her room. Resident 2 stated she used her call light at night and no one came to her room to check on her. Resident 2 stated what was the point of having a call light if staff do not answer it. Resident 2 stated she knew if she had an emergency and she used the call light no one would come to help her. Resident 2 stated she felt sad because she felt the nurses did not care enough to help her. 3. A review of Resident 3's Admission Record, indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (a condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body) and respiratory failure (serious condition that makes it difficult to breathe on their own, lungs can't get enough oxygen into the blood). A review of Resident 3's H&P dated 10/23/2023, indicated Resident 3 did not have the capacity to understand and make decisions due to a cerebral vascular accident (a loss of blood flow to part of the brain, which damages brain tissue caused by blood clots and broken blood vessels in the brain). A review of Resident 3's MDS, dated [DATE], indicated that Resident 3's cognitive skills for daily decision making was intact. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort) with oral hygiene, dressing, and personal hygiene. The MDS indicated Resident 3 was dependent on staff for toileting hygiene and shower/baths. During an interview on 7/10/2024 at 10:37 a.m. with Resident 3, in Resident 3's room, Resident 3 stated staff took too long to change her diaper. Resident 3 stated most of the time her call light was not assessible. Resident 3 stated she used her call light but staff did not answer. Resident 3 stated sometimes staff answered her call light and told her they would return but they did not return to help her. Resident 3 stated she waited 2 hours to get her diaper changed. Resident 3 stated the night shift staff and day shift staff did not answer call lights in a timely manner. During an interview on 7/11/2024 at 1:49 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated all call lights must be answered quickly. LVN 1 stated residents should only wait a couple of minutes to get their call lights answered. LVN 1 stated if call lights were not answered quickly, it delayed care. LVN 1 stated it was important to answer call lights quickly to assist with resident needs, resident safety and prevent accidents. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 2:04 p.m. with Certified Nursing Assistant (CNA 3), CNA 3 stated all staff were responsible for answering residents call lights. CNA 3 stated staff should not make residents wait to get assistance. CNA 3 stated when a CNA went on a break there were other CNAs available to assist residents with their needs. CNA 3 stated it was important to answer residents call light in a timely matter to assist residents with their needs and to prevent accidents. During an interview on 7/11/2024 at 2:26 p.m. with the Director of Staff Development (DSD), the DSD stated he expected all staff of the facility to answer resident call lights within five minutes. The DSD stated it was important to answer call lights in a timely manner to assist residents with their care needs and to provide the attention that residents need in case it was an emergency. The DSD stated if call lights were not answered in a timely manner, residents may get agitated and their care would get delayed. During an interview on 7/11/2024 at 3:45 p.m. with the Director of Nursing (DON), the DON stated she expected all staff of the facility to answer call lights in a timely manner. The DON stated all staff must answer the call light once they see it go on. The DON stated staff must ask the resident what assistance they need, and send designated staff to assist the resident. The DON stated it was important to answer call lights in a timely matter to prevent accidents and to meet resident needs. The DON stated if residents did not get their call light answered it could cause residents to be unhappy and their needs would not be met. The DON stated it was not acceptable to have residents siting on a wet diaper for a long time because it could cause skin issues and infections, and the resident would feel uncomfortable, and dirty sitting on a wet diaper. The DON stated all residents' needs should be met and all residents' diapers should be changed in a timely matter. A review of the facility's Policy and Procedure (P&P) titled Answering the Call Light dated 9/2022, indicated it was the facility purpose to ensure timely responses to the resident's requests and needs. The P&P indicated staff must ensure the call light is accessible to the resident while in bed. The P&P indicated staff must answer residents call light system immediately. The P&P indicated staff must complete what a resident asked for within five minutes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review the facility failed to provide safe oxygen administration practices for one of three sampled residents (Resident 2) when the facility failed to: 1. Ensure Resident 2 received oxygen at 2 liters per minute (LMP) per the physician's order. 2. Label Resident 2's nasal cannula (a plastic medical device to provide supplemental oxygen therapy to people who have lower oxygen levels, device goes directly into the nostrils). 3. Replace Resident 2's nasal cannula tubing after the nasal tubing prongs (portion of nasal tubing that goes into nostrils) touched the floor. These deficient practices had the potential to cause a negative respiratory outcome and increased the risk for Resident 2 to acquire a respiratory infection. Findings: During an observation on 7/10/2024 at 10:59 a.m., in Resident 2's room, Resident 2 was observed sitting up on the edge of the bed. Resident 2's nasal canula was observed on the floor. The oxygen was set at three liters ([unit of measurement] per minute [LPM]). The nasal cannula tubing was not labeled. The nasal cannula tubing had white particles in the tubing and was tangled under the oxygen compressor's (medical device that purifies air to deliver pure oxygen) wheels. Resident 2's wheelchair wheel was on top of nasal cannula tubing. A review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including respiratory failure (serious condition that makes it difficult to breathe on your own, lungs can't get enough oxygen into the blood) with hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis) and chronic pulmonary edema (condition where fluid accumulates in lung tissues, causing shortness of breath, wheezing and coughing up blood). A review of Resident 2's History and Physical (H&P) dated 5/8/2024, indicated Resident 2 could make needs known but could not make medical decisions. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/13/2024, indicated Resident 2's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating, oral hygiene, and upper body dressing and moderate assistance (helper does less than half the effort) for toileting hygiene, personal hygiene, and lower body dressing. A review of Resident 2's Order Summary Report, dated 5/6/2023, the report indicated Resident 2 had an order for oxygen at 2 LPM, via nasal cannula as needed for dyspnea (shortness of breath) on exertion. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's Care Plan for oxygen therapy, related to dyspnea due to pulmonary edema indicated the goal was for Resident 2 not to have signs and symptoms of poor oxygen absorption (when oxygen intake occurs at a slow rate, results in higher levels of carbon dioxide in the blood and lower oxygen levels). The staff's interventions indicated to administer oxygen at 2 LPM via nasal cannula as needed for dyspnea on exertion. During an interview on 7/10/2024 at 11:08 a.m. with Resident 2, in Resident 2's room, Resident 2 stated she had taken off her nasal cannula because she was afraid to trip on it. Resident 2 stated the nasal cannula tubing was stuck on something and she did not have enough slack. Resident 2 stated her nasal cannula tubing always came in contact with the floor and the staff did not care because they did not pick it up. Resident 2 stated if a staff person picked up the nasal cannula tubing from the floor, they put it back on her. Resident 2 stated staff did not get new nasal cannula tubing. Resident 2 stated she could not pick up the nasal cannula tubing from the floor because she had a vision impairment and could not see it. During an interview on 7/10/2024 at 2:36 p.m. with Licensed Vocational Nurse (LVN 1), in Resident 2's room, LVN 1 stated she put Residents 2 nasal cannula back on after being on the floor. LVN 1 stated she did not replace the nasal cannula tubing before putting it on Resident 2. LVN 1 stated Resident 2's nasal cannula tubing was supposed to be dated but it was not. LVN 1 stated she did not know how often oxygen equipment was to be changed. LVN 1 stated she did not know the facility's policy for oxygen administration, nor did she did know Resident 2's oxygen order. During an interview on 7/11/2024 at 1:33 p.m. with LVN 1, LVN 1 stated oxygen equipment was labeled with the date it was opened. LVN 1 stated oxygen equipment was labeled to inform staff that the oxygen equipment was clean and for infection control purposes. LVN 1 stated if oxygen equipment was not labeled, staff would not know when the oxygen equipment was initially set up and would increase the risk for an infection. LVN 1 stated Resident 2 was supposed to receive 2 LPM, per the physician's order. LVN 1 stated if Resident 2 received over 2 LPM, Resident 2 might develop signs of fluid overload. LVN 1 stated nasal cannula tubing had to be replaced if it touched the floor. During an interview on 7/12/2024 at 3:45 p.m. with the Director of Nursing (DON), the DON stated all licensed nurses were responsible to know the oxygen's effect on residents and they must know how to administer oxygen to residents. The DON stated all nurses must check the physician's orders prior to the start of oxygen administration. The DON stated a nurse must check the physician's orders to find out how many liters of oxygen the resident was ordered to receive. The DON stated if a resident received more oxygen than ordered it could affect the resident's lungs. The DON stated the resident's breathing would be affected because the extra continuous oxygen would cause the resident not to fully exhale properly. The DON stated it was important to deliver the correct liters of oxygen to residents to provide efficient care and to follow the physician's orders. The DON stated the licensed nurse that set up the new nasal cannula tubing and must label the tubing with the date and name of the nurse because it was important to know how long resident has had that oxygen equipment. The DON stated if the nasal cannula tubing was not labeled with the open date, staff would not know when it was due to be changed. The DON stated the reason oxygen equipment was labeled with the date was to prevent residents from acquiring infections. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled Oxygen Administration , dated 10/2010, indicated its purpose was to provide guidelines for a safe oxygen administration. The P&P indicated staff must verify doctors order before oxygen administration. The P&P indicated staff must review the residents care plan before oxygen administration.

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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** 48778 Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 5) received food according to his preference. This deficient practice had the potential to result in decreased meal intake, weight loss and malnutrition (when the body does not get enough nutrients). Findings: A review of Resident 5's Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including orthopedic (relating to the branch of medicine dealing with correction of deformities of bones or muscles) after care, diabetes (abnormal blood sugar) and hypertension (high blood pressure). A review of Resident 5's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 11/6/2023, indicated Resident 5 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 5 required supervision to substantial/maximal assistance (staff does more than half the effort) for Activities of Daily Living (ADLs) such as eating, upper and lower body dressing and toileting hygiene. A review of Resident 5's History and Physical (H&P), dated 4/16/2024, indicated Resident 5 had the capacity to understand and make decisions. During a concurrent observation, record review and interview on 7/11/2024 at 12:21 p.m. with Resident 5, Resident 5 was observed with lunch tray with bell peppers pushed off to the side of the plate. Resident 4 stated, he did not like bell peppers and the facility continued to serve bell peppers to him. A review of Resident 5's dietary slip (a paper that identified who the tray is to be served to along with prescribed diet and preferences) indicated Resident 5 disliked bell peppers. Resident 5 stated he had to order outside food on multiple occasions because he was unable to eat the food served by the facility. During a concurrent interview and record review on 7/12/2024 at 1:29 p.m. with Certified Nursing Assistant (CNA) 2, a picture of Resident 5's lunch tray and dietary slip dated 7/11/2024 were reviewed. CNA 2 stated Resident 5 disliked bell pepper and it was served on the resident's lunch tray. CNA 2 stated, CNAs should check resident's dietary trays prior to serving it to the residents. CNA 2 stated it was important to know the resident likes or dislikes and staff should have returned the tray to the kitchen to obtain a replacement tray for Resident 5. During a concurrent interview and record review on 7/12/2024 at 2:25 p.m. with Dietary Supervisor (DS), a picture of Resident 5's lunch tray and dietary slip dated 7/11/2024 were reviewed. DS stated, it was important for staff to check resident's trays prior to serving it to the residents to ensure the resident received food according to the resident's diet and food preferences. DS stated food was important and resident needs would not be met if the residents were served food they did not like. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's P&P titled, Food and Nutrition Services dated 10/2017, indicated each resident should be provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, and took into consideration the preferences of each resident. The P&P indicated Food and Nutrition Services staff were to inspect food trays to ensure the correct meal was provided to each resident. The P&P also indicated, nursing staff were to report to the service manager to make sure a new tray was issued to the resident, if an incorrect meal was provided to a resident, or a meal did not appear palatable.