

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Briarcrest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</p> <p>Based on interview and record review, the facility failed to obtain an informed consent (process of communication between resident/responsible party and health care provider that often leads to agreement or permission for care, treatment, or services) prior to the administration of psychotropic medication (medications that affect the mind, emotions, and behavior) for one out of one sampled resident (Residents 1).</p> <p>1. The facility did not ensure an informed consent was obtained when lorazepam (medication that relieves symptoms of anxiety, causes paranoid or suicidal ideation and impairs memory, judgment, and coordination) medication dosage was increased from 0.5 milligrams (mg, unit of measurement) to 1 mg for Resident 1.</p> <p>This deficient practice violated Resident 1 ' s right to make an informed decision prior to the administration of lorazepam medication.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (an intense, excessive, and persistent worry and fear about everyday situations) and depression (a common and serious medical illness that negatively affects how a person feels, the way a person thinks and how they act. It causes feelings of sadness and/or a loss of interest in activities a person once enjoyed).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/5/2024, the MDS indicated Resident 52 ' 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, toileting hygiene, personal hygiene, and shower/bathing self. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) for dressing and putting shoes on.</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 7/2/2024, H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Order Summary Report dated 7/13/2024, the Order Summary Report indicated Resident 1 was ordered to receive Lorazepam 1 milligram (mg) tablet every 12 hours as needed for anxiety.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s medical chart, the medical chart did not have an informed consent for the administration of lorazepam 1 mg medication.</p> <p>During a concurrent interview and record review on 8/13/2024 at 2:49 p.m. with Licensed Vocational Nurse (LVN 1), Resident 1 ' s medical chart was reviewed. LVN 1 stated she did not find the informed consent for lorazepam 1 mg. LVN 1 stated a nurse must verify if there was an informed consent prior to the administration of an antipsychotic medication. LVN 1 stated every time there was a change in dosage for an antipsychotic medication, the licensed nurse must obtain an informed consent. LVN 1 stated Resident 1 received a medication that she did not consent to receive. LVN 1 stated it was important to get an informed consent to inform Resident 1 of new medication dosage and to get Resident 1 ' s consent to receive medication. LVN 1 stated the licensed nurses were liable of administering medication to Resident 1 without her being aware of the medication change and without her giving her consent.</p> <p>During an interview on 8/13/2024 at 3:43 p.m. with LVN 2, LVN 2 stated a nurse must check if there was an informed consent before the administration of the antipsychotic medication. LVN 2 stated the inform consent was the acknowledgement that a resident was informed about the medication and the resident gave their consent to receive the medication. LVN 2 stated a new informed consent was needed when the dosage of an antipsychotic medication was increased or decreased. LVN 2 stated Resident 1 needed an informed consent for Lorazepam because it was a chemical restraint. LVN 2 stated lorazepam should have not been administered to Resident 1 because there was no informed consent for that medication.</p> <p>During an interview on 8/13/2024 at 4:22 p.m. with Registered Nurse (RN 2), RN 2 stated when there was an increase on a medication a new informed consent was needed. RN 2 stated if a medication dosage was increased and there was no informed consent for the new dosage, the facility would not be in compliance and the medication should have not been administered to Resident 1. RN 2 stated it was important to have an informed consent for all staff to be on the same page with the care for Resident 1.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled Resident Rights, dated 2/2021, the P&P indicated residents had the right to be informed of, and participate in, his or her care planning and treatment.</p> <p>During a review of the facility ' s P&P titled Antipsychotic Medication Use, dated 7/2022, the P&P indicated all residents will be informed of the recommendation, risk, benefits, purpose and potential adverse consequences of antipsychotic use and residents may refuse medications of any kind.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</p> <p>During an interview and record review, the license nurses failed to review, update, and/or revise a care plan (written document developed for each individual by the support team using a person-centered approach that describes the supports, services, and resources provided or accessed to address the needs of the individual) to reflect the physician current order for lorazepam (medication that relieves symptoms of anxiety [feeling of unease, excessive worry]) for one out of one sampled resident (Resident 1).</p> <p>This deficient practice had the potential to result in Resident 1 not receiving an accurate dose of lorazepam and had the potential to negatively affect Resident 1 ' s physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (an intense, excessive, and persistent worry and fear about everyday situations) and depression (a common and serious medical illness that negatively affects how a person feels, the way a person thinks and how they act. It causes feelings of sadness and/or a loss of interest in activities a person once enjoyed).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/5/2024, the MDS indicated Resident 52 ' 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, toileting hygiene, personal hygiene, and shower/bathing self. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) for dressing and putting shoes on.</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 7/2/2024, H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Order Summary Report dated 7/13/2024, the Order Summary Report indicated Resident 1 was ordered to receive Lorazepam 1 milligram (mg, unit of measurement) tablet every 12 hours as needed for anxiety.</p> <p>During a review of Resident 1 ' s Care Plan for anti- anxiety medication related to anxiety disorder dated 5/6/2024, it indicated the goal was for Resident 1 to be free from discomfort or adverse reactions related to anti-anxiety therapy. The care plan indicated the interventions was to administer Lorazepam 0.5 mg tablet every 12 hours as needed for anxiety and to administer anti-anxiety medication as ordered by physician.</p> <p>During an interview on 8/13/2024 at 3:21 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated when a medication dosage was increased or decreased, the care plan must be revised. LVN 2 stated care plans served as a plan of care for nurses to follow. LVN 2 stated if the care plan was not revised, nurses would not know of the new medication order.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/13/2024 at 4:22 p.m. with Registered Nurse (RN 2), RN 2 stated a care plan must be revised when the doctor increased or decreased a medication. RN 2 stated it was important to revise care plans to provide a continuous care to the residents. RN 2 stated when Lorazepam was increased from 0.5 mg to 1 mg, the licensed nurse should have revised the care plan to reflect the new doctor order. The RN 2 stated care plans must be revised because it is the plan of care that licensed nurses must follow to safely care for residents. RN 1 stated if a care plan was not revised when there was a new medication order, the licensed nurses would not administer the correct medication to the resident.</p> <p>During a review of the facility ' s Policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change.</p>