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	12/30/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to follow its Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation- Reporting and Investigating which indicated injuries of unknown source would be reported to the State Licensing/Certification Agency within two hours for one of four sampled residents (Resident 1) when Resident 1 developed new, multiple skin discolorations and bruising (collection of blood underneath the skin that is caused by an injury)to the left cheek and chin. This failure delayed the investigation by the State Agency and placed Resident 1 at risk for continuous abuse. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood), hepatic encephalopathy (brain dysfunction due to liver dysfunction that can cause issues with thinking and mobility) and coagulation defect (a condition that affects the ability to control bleeding). During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/20/2024, the MDS indicated Resident 1 did not speak and was rarely/never able to make their needs known and rarely/never able to understand verbal content. The MDS indicated Resident 1 was totally dependent on staff for Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene, personal hygiene, dressing and bed mobility (ability to roll from lying on back to left and right side and return to lying on back on the bed). During a record review of Resident 1's History and Physical (H&P), dated 12/21/2024, the H&P indicated Resident 1 did not have the ability to understand and make decisions. During a record review of Resident 1's SBAR Communication Form ([Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change in condition among the residents), dated 12/4/2024, the SBAR indicated, Resident 1 was observed with light brown skin discoloration to the left cheek. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's SBAR, dated 12/9/2024, the SBAR indicated, Resident 1 was noted with multiple discolorations to the left shoulder, right shoulder, left thigh and right elbow. During a record review of Resident 1's Progress Note, dated 12/12/2024, the Progress Note indicated Resident 1 had bruising on the resident's left lower chin. During a concurrent interview and record review on 12/30/2024 at 2:50 p.m. with Registered Nurse 1 (RN 1), Resident 1's SBAR Communication Form, Progress Notes and H&P were reviewed. RN 1 stated Resident 1's cheek discoloration was a bruise, measured 3 cm x 3 cm and grew twice as large later (size unknown). RN 1 stated neuro check was ordered by the physician for Resident 1 out of concern for mentation changes since facial bruising could have been caused by trauma to the resident's head. RN 1 stated the cause of Resident 1's facial skin discoloration and bruising were considered injuries of unknown source and should have been reported to the State Agency immediately. During an interview on 12/30/2024 at 3:45 p.m. with the Administrator (Admin), Admin stated, Resident 1's skin discolorations and bruises were not reported to the State Agency because they were attributed to the resident's condition. Admin stated, staff did not know how the bruise occurred or developed and should have been reported to the State Agency and investigated instead of just attributing the bruise to medical conditions. During a review of the facility's P&P titled, Investigating Injuries dated 12/2016, the P&P indicated an injury of unknown source was an injury that was not observed by any person, the source of injury could not be explained by the resident, and the injury was suspicious due to the injury's extent, location, quantity, or incidents over time. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, the P&P indicated the facility will identify all possible incidents of abuse or mistreatment. The P&P indicated the facility will report any allegations within timeframes required by federal requirements. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation- Reporting and Investigating, dated 7/2022, the P&P indicated the facility will report resident abuse (including injuries of unknown origin) to local, state, and federal agencies (as required by current regulations). The P&P indicated if injury of unknown source is suspected, the suspicion must be reported immediately (within two hours of an allegation involving abuse or within 24 hours of an allegation that does not involve abuse) to the Administrator and to other officials according to state law.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to investigate injuries of unknown source for one of four residents (Resident 1) when Resident 1 developed new, multiple skin discolorations and bruising (collection of blood underneath the skin that is caused by an injury) to the left cheek and chin. This failure had the potential to result in unidentified abuse and placed Resident 1 at risk for continuous abuse. Findings: During a record review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood), hepatic encephalopathy (brain dysfunction due to liver dysfunction that can cause issues with thinking and mobility) and coagulation defect (a condition that affects the ability to control bleeding). During a record review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 10/20/2024, the MDS indicated Resident 1 did not speak and was rarely/never able to make their needs known and rarely/never able to understand verbal content. The MDS indicated Resident 1 was totally dependent on staff for Activities of Daily Living (ADLs) such as oral hygiene, toileting hygiene, personal hygiene, dressing and bed mobility (ability to roll from lying on back to left and right side and return to lying on back on the bed). During a record review of Resident 1 ' s History and Physical (H&P), dated 12/21/2024, the H&P indicated Resident 1 did not have the ability to understand and make decisions. During a record review of Resident 1 ' s SBAR Communication Form ([Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change in condition among the residents), dated 12/4/2024, the SBAR indicated, Resident 1 was observed with light brown skin discoloration to the left cheek. During a record review of Resident 1 ' s SBAR, dated 12/9/2024, the SBAR indicated, Resident 1 was noted with multiple discolorations to the left shoulder, right shoulder, left thigh and right elbow. During a record review of Resident 1 ' s Progress Note, dated 12/12/2024, the Progress Note indicated Resident 1 had bruising on the resident ' s left lower chin. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/30/2024 at 2:50 p.m. with Registered Nurse 1 (RN 1), Resident 1 ' s SBAR Communication Form, Progress Notes and H&P were reviewed. RN 1 stated Resident 1 ' s cheek discoloration was a bruise, measured 3 cm x 3 cm and grew twice as large later (size unknown). RN 1 stated neuro check was ordered by the physician for Resident 1 out of concern for mentation changes since facial bruising could have been caused by trauma to the resident ' s head. RN 1 stated the cause of Resident 1 ' s facial skin discoloration and bruising were considered injuries of unknown source and should have been investigated. RN 1 stated residents were at risk of abuse because no investigation was conducted, and abuse was not ruled out for Resident 1. During an interview on 12/30/2024 at 3:45 p.m. with the Administrator (Admin), Admin stated, Resident 1 ' s skin discolorations and bruises were not thoroughly investigated because they were attributed to the resident ' s medical history. Admin stated, Resident 1 ' s injuries of unknown source (skin discoloration and bruising) should have been thoroughly investigated instead of just attributing them to the resident ' s medical conditions. During a review of the facility ' s Policy and Procedure (P&P) titled, Investigating Injuries dated 12/2016, the P&P indicated the Administrator will ensure that all injuries are investigated and will follow the protocols set forth in the facility ' s established abuse investigation guidelines. The P&P indicated an injury of unknown source was an injury that was not observed by any person, the source of injury could not be explained by the resident, and the injury was suspicious due to the injury ' s extent, location, quantity, or incidents over time. During a review of the facility ' s P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, the P&P indicated the facility will identify and investigate all possible incidents of abuse or mistreatment. The P&P indicated the facility will investigate any allegations within timeframes required by federal requirements.