

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 03/01/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure the safety of one of eight sampled residents (Resident 1) at risk for wandering by failing to:</p> <ol style="list-style-type: none"> 1. Ensure the front and back exit doors were monitored, after the front lobby exit door alarm was activated by Resident 1 on 2/24/2025 at 7:43 p.m. 2. Closely monitor Resident 1's whereabouts in the facility after he attempted to leave from the front exit door on 2/24/2025 at 7:43 p.m. 3. Educate Resident 1 on the risk of leaving the facility after his first elopement (the act of leaving a facility unsupervised and without prior authorization) attempt on 2/24/2025 at 7:43 p.m. 4. Ensure the facility's back exit door alarm was activated on 2/24/2025. <p>As a result, Resident 1 eloped from the facility's back exit door on 2/24/2025 at 7:47 p.m., four minutes after activating the front exit door alarm.</p> <p>On 2/28/2025 at 2:15 p.m., an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) due to the facility's failure to provide supervision to Resident 1 on 2/24/2025 at 7:43 p.m. and failure to prevent Resident 1's elopement from the facility on 2/24/2025 at 7:47 p.m.</p> <p>On 3/1/2025 at 1:46 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed while onsite at 3/1/2025 at 3:25 p.m., in the presence of the ADM.</p> <p>The IJRP included the following immediate actions:</p> <ol style="list-style-type: none"> 1. On 2/24/2025 at 9:30 p.m., staff immediately initiated a search of the inside and outside of the facility including streets, and nearby areas in partnership with the local Police Department. <p>(i) Facility-wide search for Resident 1 initiated by Registered Nurse (RN) 1 and staff on 2/24/2025 at 9:30 p.m.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(ii) Headcount completed by RN 1 on 2/24/2025 after Resident 1 was found missing.</p> <p>(iii) The ADM, the Director of Nursing (DON), and the Maintenance Supervisor (MS) were notified by RN 1 of Resident 1's elopement on 2/24/2025.</p> <p>2. Immediate in-service trainings were conducted from 2/24/2025 - 3/1/2025:</p> <p>a. All staff were trained on elopement policies, procedures, and risks by the Director of Staff and Development (DSD) and the DON.</p> <p>b. Certified Nursing Assistant (CNA) 1 and CNA 2 were counseled and retrained on reporting alarms and elopement supervision by the DON and DSD on 2/28/2025 and 2/24/2025.</p> <p>c. Weekly in-services would be initiated by the DSD for eight weeks for all shifts.</p> <p>3. Identification of other at-risk residents:</p> <p>a. All residents were reassessed for elopement risk by the DON on 2/25/2025.</p> <p>b. On 2/27/2025, one newly admitted resident identified as high-risk for elopement.</p> <p>c. Care plans updated accordingly.</p> <p>4. Measures to prevent recurrence:</p> <p>a. Admission & Care Planning Process:</p> <p>(i) All new/readmitted residents assessed for elopement risk by the Inter-Disciplinary Team (IDT, a group of different disciplines working together towards a common goal for a resident) members and/or the DON.</p> <p>(ii) Comprehensive assessments of residents conducted at least quarterly or upon status change by the Minimum Data Set (MDS) Coordinator.</p> <p>(iii) Residents' care plans updated to reflect elopement risk by the MDS Coordinator and/or the DON.</p> <p>b. Facility security measures:</p> <p>(i) Exit door Monitoring:</p> <p>1. Backdoor exit to be constantly supervised, maintained and validated by the MS daily from Monday to Friday and manager of the day for Saturday and Sunday. The MS to maintain a log and to be audited by the ADM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(ii) Ongoing audits would be reported monthly for six months, then quarterly by the DON and the ADM and/or designee.</p> <p>(iii) The facility would sustain compliance through continuous monitoring and training.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), difficulty in walking, and schizophrenia (a mental illness that was characterized by disturbances in thought).</p> <p>During a review of Resident 1's MDS (a resident assessment tool), dated 2/14/2025, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 required set up assistance with eating, and supervision with oral hygiene, personal hygiene, and walking. The MDS indicated Resident 1 had wandering behaviors (the act of roaming around and becoming lost or confused about his location).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 11/7/2024, the H&P indicated Resident 1 could make his needs known but could not make medical decisions.</p> <p>a. During a telephone interview on 2/27/2025 at 12:42 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 2/24/2025 at 7:30 p.m., he saw Resident 1 exit his room. CNA 1 stated on 2/24/2025 at 7:43 p.m., while changing Resident 3 (Resident 1's roommate) he heard the front exit door alarm. CNA 1 stated he walked out of the room to check the alarm and saw Resident 1 by the door. CNA 1 stated he redirected Resident 1 back to the hallway, and Resident 1 walked down the hallway toward the nursing station. CNA 1 stated he did not report the incident to the charge nurse for further interventions like closer monitoring of the exit doors.</p> <p>During a telephone interview on 2/27/2025 at 1:59 p.m. with Registered Nurse (RN) 1, RN 1 stated on 2/24/2025 at 7:43 p.m., no one reported to him that Resident 1 activated the front exit door alarm. RN 1 stated CNA 1 should have informed the RN supervisor and charge nurses for immediate interventions.</p> <p>During a telephone interview on 2/27/2025 at 2:18 p.m., with CNA 2, CNA 2 stated on 2/24/2025 around 7:43 p.m., she went to use the restroom located near the facility's front exit door. CNA 2 stated she heard the front exit door alarm and saw Resident 1 standing at the door. CNA 2 stated she called Resident 1 by his name but the resident did not respond and continued to walk down the hallway. CNA 2 stated she thought the alarm was activated because Resident 1 got too close to the door. CNA 2 stated she did not think Resident 1 was trying to elope. CNA 2 stated she did not report the incident to anyone. CNA 2 stated the exit doors should have been closely monitored after the front exit door was activated by Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/2025 at 2:58 p.m. with the Director of Staff Development (DSD), the DSD stated on 2/24/2025 at 7:43 p.m., CNAs 1 and 2 were aware that Resident 1 activated the front exit door alarm. The DSD stated CNAs 1 and 2 should have notified the charge nurse so the charge nurse could follow up and ensure Resident 1's safety and ensure the exit doors were monitored.</p> <p>During a concurrent interview and video review on 2/28/2025 at 8:58 a.m. with the Administrator (ADM), the facility's security surveillance video footage, dated 2/24/2025 from 7:43 p.m. to 7:48 p.m., was reviewed. The ADM stated at 7:47 p.m., the surveillance footage revealed Resident 1 pushed open the back exit door and walked out of the facility through the parking lot and onto the street. The ADM stated, there was no staff present at the back exit door. The ADM stated the back door should have been supervised.</p> <p>During an interview on 2/28/2025 at 4:04 p.m. with RN 2, RN 2 stated on 2/24/2025 at 7:43 p.m., staff should have made sure the facility's front and back doors were secured at all times after the front exit door alarm was activated.</p> <p>b. During a telephone interview on 2/27/2025 at 12:42 p.m. with CNA 1, CNA 1 stated 2/24/2025 at 7:43 p.m. was his last time seeing Resident 1 after the resident activated the front exit door alarm. CNA 1 stated he did not check on Resident 1 after that because he was busy changing other residents. CNA 1 stated he should have checked on Resident 1 after the resident activated the alarm. CNA 1 stated on 2/24/2025 at 9:30 p.m., he could not find Resident 1, and did not know what time Resident 1 left the facility.</p> <p>During a telephone interview on 2/27/2025 at 1:59 p.m. with RN 1, RN 1 stated on 2/24/2025 around 7:43 p.m., he heard the front exit door alarm but did not see anyone. RN 1 stated he continued to work on his admission and did not inquire on who or what activated the alarm. RN 1 stated after the alarm was activated staff should have checked to see if a resident left the facility, and the resident should have been placed on close monitoring, similar to one-on-one (1:1, a dedicated nurse assigned to continuously observe and attend to a single resident at all times, providing close supervision and immediate interventions when needed) supervision. RN 1 stated he would have assigned 1:1 supervision for Resident 1 or placed Resident 1 at the nursing station so he (RN 1) could monitor Resident 1. RN 1 stated on 2/24/2025 at 9:30 p.m., Licensed Vocational Nurse (LVN) 1 and LVN 2 informed him that Resident 1 was missing.</p> <p>During a telephone interview on 2/27/2025 at 2:26 p.m. with LVN 2, LVN 2 stated on 2/24/2025 around 7:40 p.m., she was told by staff (unable to recall name) that Resident 1 activated the front exit door alarm. LVN 2 stated staff were to make rounds every 15 minutes to check on wandering residents and make sure the residents' wander guards (a safety system used to prevent residents from wandering into unsafe areas or elopement) were on. LVN 2 stated the charge nurse should have checked Resident 1's wander guard placement after Resident 1 activated the alarm on 2/24/2025 at 7:43 p.m. LVN 2 stated Resident 1 was not her assigned resident and that was why she did not do so. LVN 2 stated on 2/24/2025 at 9 p.m., LVN 1 notified her (LVN 2) that Resident 1 was missing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/2025 at 2:58 p.m. with the DSD, the DSD stated all CNAs should monitor all wandering residents by keeping an eye on them. The DSD stated if residents were observed wandering, trying to go to the patio, or had their belongings with them, staff were supposed to recognize those signs as elopement risk. The DSD stated RNs were supposed to immediately perform rounds to ensure all residents were in the facility. The DSD stated if the RNs did not see anything, they were supposed to find out who activated the alarm and what happened. The DSD stated the LVNs were supposed to monitor residents who activated the alarm and perform more frequent rounds.</p> <p>During a telephone interview on 2/27/2025 at 3:42 p.m. with LVN 1, LVN 1 stated on 2/24/2025 around 7:40 p.m., she was in another room and did not hear the alarm. LVN 1 stated on 2/24/2025 around 7:45 p.m., she observed Resident 1 in bed. LVN 1 stated Resident 1 was on hourly monitoring for his wandering behaviors and had a wander guard. LVN 1 stated on 2/24/2025 at 9 p.m., CNA 1 reported to her that Resident 1 activated the alarm around 7:40 p.m. and was now missing. LVN 1 stated she would have notified RN 1 at 7:45 p.m. if she was aware that Resident 1 activated the front exit door alarm and ensure Resident 1 was closely monitored. LVN 1 stated all staff was responsible for ensuring residents' safety.</p> <p>During an interview on 2/27/2025 at 4:16 p.m. with the DON, the DON stated Resident 1 activating the alarm was an exit-door-seeking behavior. The DON stated staff should assess the needs of residents with exit-door-seeking behavior and implement interventions. The DON stated when staff observed Resident 1's exit-door-seeking behavior, the licensed nurses should have documented the exit-door-seeking behavior in the resident's medical record and implemented closer monitoring. The DON stated on 2/24/2025 at 7:43 p.m., RN 1 and LVN 1 should have inquired to find out who activated the alarm and/or whether it was a false alarm so staff could do closer monitoring to ensure Resident 1's safety.</p> <p>c. During a review of Resident 1's care plan titled At risk for elopement/wandering, initiated 11/8/2024, the care plan indicated Resident 1 would have no incident of elopement and wandering outside of the facility property daily. The care plan interventions indicated will remind Resident 1 regularly and as needed (PRN) and explain risks and benefits of elopement/wandering.</p> <p>During a telephone interview on 2/27/2025 at 12:42 p.m. with CNA 1, CNA 1 stated on 2/24/2025 at 7:43 p.m., he did not educate Resident 1 on the risks of leaving the facility without supervision after Resident 1 activated the front exit door alarm.</p> <p>During a telephone interview on 2/27/2025 at 2:18 p.m., with CNA 2, CNA 2 stated on 2/24/2025 around 7:43 p.m., she called Resident 1 by his name after Resident 1 activated the front exit door alarm, but did not educate Resident 1 on the risks of leaving the facility unsupervised.</p> <p>d. During a concurrent observation and interview on 2/26/2025 at 3:40 p.m. with the Maintenance Supervisor (MS), the back exit door alarm was flashing with a high pitched sound when activated. The MS stated the alarm lit up when activated.</p> <p>During a concurrent interview and video review on 2/28/2025 at 8:58 a.m. with the ADM, the facility's security surveillance video footage, dated 2/24/2025 from 7:43 p.m. to 7:48 p.m., was reviewed. The ADM stated at 7:47 p.m., the surveillance footage revealed Resident 1 pushed open the back exit door, and the alarm did not light up.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised in 7/2017, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . a facility-wide commitment to safety at all levels of the organization .The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. The P&P indicated Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs. The P&P indicated implementing interventions to reduce accident risks and hazards shall include the following:</p> <ul style="list-style-type: none"> a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions c. Ensuring that interventions are implemented d. Ensuring that interventions are implemented correctly and consistently. <p>During a review of the facility's P&P titled, Wandering and elopements, undated, the P&P indicated If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.</p>