

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 05/06/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on observation, interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 1) supervised the medication administration for one of three sampled residents (Resident 2), who had not been assessed by the Interdisciplinary Care Team (IDT- a group of healthcare professionals who work together to manage the resident ' s care) for medication self-administration.</p> <p>This failure placed Resident 2 at risk for medication errors including delayed doses or missed doses and could lead to adverse drug events for the resident.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 2 ' s diagnoses included osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) of the left hip, hypertensive urgency (a significantly elevated blood pressure [normal pressure is 120/80 millimeter of mercury ([mmHG], a unit of pressure)) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 2 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes activity) for Activities of Daily Living (ADLs) such as eating and oral hygiene.</p> <p>During a concurrent observation and interview on 5/6/2024 at 10:44 a.m. with Resident 2 at the resident ' s bedside, Resident 2 was observed holding a small plastic disposable medicine cup with approximately 5 medications: one small black, circular pill, one orange capsule, one white oval shaped pill with the number, 145, and two white pills. No licensed nurse was observed present with the resident. Resident 2 stated the pills were medications she was taking for blood pressure and blood sugar.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/6/2025 at 10:47 a.m. at Resident 2 ' s bedside with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the medications inside the medicine cup with the Resident 2 were Colace (a stool softener to treat constipation) and Pradaxa (a medication that prevents blood clots from forming). LVN 1 stated the medications were scheduled to be administered to Resident 2 at 9:00 a.m. and she (LVN 1) left the medications with the resident because the resident preferred to take the medications on her own.</p> <p>During a review of Resident 2 ' s Order Summary Report dated 5/6/2025, the Report indicated the following physician orders for Resident 2:</p> <p>On 2/4/2025, the physician ordered to administer amlodipine besylate (medication to treat high blood pressure) 5 milligrams (mg.- unit of measurement) give 1 tablet by mouth one time a day, ascorbic acid (supplement) 500 mg. 1 tablet by mouth one time a day, bisoprolol fumarate (medication to treat high blood pressure) 5 mg. give 1.5 tablet by mouth one time a day with food, docusate sodium (colace) 250 mg. give 1 capsule by mouth one time a day, ferrous sulfate (iron supplement) 325 mg. by mouth one time a day, every other day, gabapentin (medication to treat nerve pain) 400 mg. by mouth three times a day and hydralazine (medication to treat high blood pressure) 50 mg. give 1 tablet by mouth three times a day.</p> <p>On 3/6/2025, the physician ordered to administer Pradaxa 110 mg. 1 capsule by mouth two times a day.</p> <p>During an interview on 5/6/2025 at 12:01 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she observed a medication cup with Resident 2 ' s medications left on top of Resident 2 ' s bedside table in the morning (no time specified). CNA 1 stated she should have informed the charge nurse but had forgotten to do so.</p> <p>During an interview on 5/6/2025 at 1:31 p.m. with Registered Nurse (RN) 1, RN 1 stated, it was not acceptable for medications to be left unattended at a resident ' s (Resident 2 ' s) bedside without a licensed nurse. RN 1 stated, a licensed nurse should be present with the resident when administering medications, to ensure that all medications were taken and to ensure safety of the resident.</p> <p>During an interview on 5/6/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated residents should first be evaluated by the IDT prior to the resident self-administering medication, to ensure the resident was able to safely do so and after a care plan had been initiated. The DON stated that an IDT had not been done for Resident 2 until about 30 minutes ago. The DON also stated medications for Resident 2 should not have been left unattended earlier in the morning, for the resident to take by herself because there was no physician ' s order, and an IDT had not yet been conducted.</p> <p>During a review of facility ' s undated policy and procedure (P&P) titled, Self-Administration of Medications, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The P&P also indicated, As part of the evaluation comprehensive assessment, the IDT assesses each resident ' s cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The P&P indicated, the IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident:</p> <p>(continued on next page)</p>		

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