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	08/19/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's medical records were complete and accurately documented for one of two sampled residents (Resident 2) by not ensuring licensed nurses1. Documented the number of behavioral episodes on the Medication Administration record (MAR);2. Monitored Resident 2 for behavioral episodes (period or event marked by unusual, disruptive, or problematic behavior);3. Had the knowledge to complete monitoring section in the MAR; and4. Licensed nurses documented Resident 2' s return to the facility.These deficient findings could potentially place other residents in the facility at risk to Resident 2's behavioral episodes. These deficient findings created miscommunication on when and at what time Resident 2 returned to the facility.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. Resident 2's diagnosis included schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety (intense, excessive and persistent worry and fear about everyday situations).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/24/2025, the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required moderate assistance (helper does less than half) with oral hygiene, toileting hygiene, lower body dressing and putting on/taking off shoes. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with shower/bathing and personal hygiene.During a review of Resident 2's H&P dated 8/8/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's Order Summary Report dated 8/8/2025, the order summary report indicated Resident 2 had an order for quetiapine (helps regulate mood, behavior and thoughts) oral tablet 100 milligrams (mg- metric unit of measurement), one tablet at bedtime for manic (mental state of an extreme highs or depressive lows) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 2's Medication Administration record (MAR), dated 8/7/2025, the MAR indicated there was an order to monitor Resident 2 for agitation and aggressive behavior every shift for use of quetiapine. The MAR indicated for the shifts of 8/8/2025 from 7 a. m. to 3 p.m. and 3 p.m. to 11 p.m., and for 8/9/2025 from 7 a.m. to 3 p.m., the monitoring for those shifts was not done.During a review of Resident 2's Nursing Progress notes, dated 8/10/2025 at 10:58 p.m., Progress Note indicated Resident 2 displayed mild agitation.During a review of Resident 2's MAR, dated 8/9/2025, the MAR indicated there was an order to monitor Resident 2 for extreme mood swings with intense irritability for the use of quetiapine. The MAR indicated on 8/10/2025, Resident 2 did not display any behavioral episodes (period or event marked by unusual, disruptive, or problematic behavior). The MAR indicated on 8/11/2025 from 7 a.m. to 3 p.m., the word yes was documented under number of episodes of behavior. The MAR indicated for 8/11/2025 from 3 p.m. to 11 p.m., the behavioral monitoring for that shift was not done.During a review of Resident 2's MAR, dated 8/11/2025, the MAR indicated there was an order to monitor Resident 2 every shift for screaming and yelling for the use of quetiapine. The MAR indicated for 8/11/2025 from 3 p.m. to 11 p.m., the behavioral monitoring for that shift was not done. The MAR indicated on 8/12/2025 from 3 p. m. to 11 p.m., the letter n was documented under number of episodes of behavior.During a review of Resident 2's Nursing Progress notes, dated 8/11/2025 at 6:45 p.m., the Progress Note indicated Resident 2 displayed frustration regarding smoking break policy. The nursing progress note indicated Resident 2 became argumentative with staff. The nursing progress notes indicated Resident 2 voiced concerns in an elevated tone.During a review of Resident 2's Nursing Progress notes, dated 8/11/2025 at 9:15 p.m., Progress Notes indicated Resident 2 became hostile, raised his voice and said demeaning comments to staff. During a review of Resident 2's Order Summary Report dated 8/11/2025, the order summary report indicated Resident 2 had an order for Ativan (slows the activity of the brain and nerves) oral tablet 0.5 mg, every six hours as needed for anxiety.During a review of Resident 2's MAR, dated 8/11/2025 at 4:21 p.m., MAR indicated there was an order to monitor Resident 2 every shift for anxiety manifested by restlessness and agitation while using Ativan. The MAR indicated on 8/11/2025 from 3 p.m. to 11 p.m., behavioral monitoring was not done. The MAR indicated on 8/12/2025 from 7 a.m. to 3 p.m., Resident 2 had two behavioral episodes, and indicated No for behavioral episodes.During a review of Resident 2's Nursing Progress notes, dated 8/12/2025 at 11:30 a.m., Progress Notes indicated Resident 2 had a physical altercation with another