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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056220 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                           | (X3) DATE SURVEY COMPLETED<br><br>11/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Briarcrest Nursing Center |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5648 East Gotham Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an allegation of staff-to-resident abuse to the California Department of Public Health (CDPH) timely for one of two sampled residents (Resident 1). This deficient practice placed Resident 1, and other facility residents, at risk of sustaining abuse. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and recently re-admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), quadriplegia (inability to move the extremities), tracheostomy (a surgical opening in the neck into the trachea (windpipe) that creates a new airway for breathing through a tube), gastrostomy (the surgical procedure to create an opening through the abdominal wall into the stomach). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1 had severe cognitive impairment (a significant loss of mental function that affects daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 1's Post-Event Review, dated 11/10/2025, the Post-Event Review indicated an Interdisciplinary Team (IDT) Meeting was conducted on 11/11/2025 with Resident 1's son, Responsible Party (RP) 1. The record indicated RP told the IDT that Resident 1 alleged he was hit by an unidentified male Certified Nursing Assistant (CNA). During an interview on 11/14/2025 at 1:50 p.m., with the Director of Nursing (DON), the DON stated RP 1 reported the allegation that Resident 1 was hit by a male CNA on 11/11/2025. The DON stated it was considered an allegation of physical abuse, regardless of RP 1's, or Resident 1's, ability to recall when it occurred or identify the exact male CNA. The DON stated the allegation was not reported to the State Agency (SA). The DON stated the allegation should have been reported within two hours. The DON stated it was important to report all allegations of abuse for resident safety. During an interview on 11/14/2025 at 2:23 p.m., with the Administrator (ADM), the ADM stated he was aware of RP 1's allegation that Resident 1 was hit by a male CNA. The ADM stated this was an allegation of physical abuse and stated it was not reported to the SA. The ADM stated the allegation should have been reported to protect the facility residents. During a review of the facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, the P&amp;P indicated staff were to report any allegations of abuse within the timeframes required by federal requirements. During a review of the facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, revised 9/2022, the P&amp;P indicated any suspicions of resident abuse were to be reported within two hours.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                           | (X3) DATE SURVEY COMPLETED<br><br>11/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Briarcrest Nursing Center                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5648 East Gotham Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                |                                              |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure an allegation of staff-to-resident abuse was investigated for one of two sampled residents (Resident 1). This deficient practice placed Resident 1, and other facility residents, at risk of potential abuse. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and recently re-admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), quadriplegia (inability to move the extremities), tracheostomy (a surgical opening in the neck into the trachea (windpipe) that creates a new airway for breathing through a tube), gastrostomy (the surgical procedure to create an opening through the abdominal wall into the stomach). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1 had severe cognitive impairment (a significant loss of mental function that affects daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 1's Post-Event Review, dated 11/10/2025, the Post-Event Review indicated an Interdisciplinary Team (IDT) Meeting was conducted on 11/11/2025 with Resident 1's son, Responsible Party (RP) 1. The record indicated RP told the IDT that Resident 1 alleged he was hit by an unidentified male Certified Nursing Assistant (CNA). During an interview on 11/14/2025 at 1:50 p.m., with the Director of Nursing (DON), the DON stated RP 1 reported the allegation that Resident 1 was hit by a male CNA on 11/11/2025. The DON stated it was considered an allegation of physical abuse, regardless of RP 1's, or Resident 1's, ability to recall when it occurred or identify the exact male CNA. The DON stated the allegation was not investigated and stated it was important to investigate all allegations of abuse for resident safety. During an interview on 11/14/2025 at 2:23 p.m., with the Administrator (ADM), the ADM stated he was aware of RP 1's allegation that Resident 1 was hit by a male CNA. The ADM stated this was an allegation of physical abuse and it was not investigated. The ADM stated it was important to investigate all allegations of abuse to protect the facility's residents. During a review of the facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, the P&amp;P indicated staff were to investigate any abuse allegations within the timeframes required by federal requirements. During a review of the facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, revised 9/2022, the P&amp;P indicated all abuse allegations were to be thoroughly investigated, and the investigations were to be initiated by the Administrator.</p> |                                                                                                |                                              |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, Registered Nurse (RN) 1 failed to conduct neurological assessments ( neuro-checks, assessments that evaluate brain and nervous system functioning) at the required frequency/interval for one of two sampled residents (Resident 1) after Resident 1 was allegedly hit on the head by a male Certified Nursing Assistant (CNA). This deficient practice placed Resident 1 at risk of staff not identifying, or being delayed in identifying, potential neurological complications. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and recently re-admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), quadriplegia (inability to move the extremities), tracheostomy (a surgical opening in the neck into the trachea (windpipe) that creates a new airway for breathing through a tube), gastrostomy (the surgical procedure to create an opening through the abdominal wall into the stomach). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/31/2025, the MDS indicated Resident 1 had severe cognitive impairment (a significant loss of mental function that affects daily life). The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 1's Post-Event Review, dated 11/10/2025, the Post-Event Review indicated an Interdisciplinary Team (IDT) Meeting was conducted on 11/11/2025 with Resident 1's son, Responsible Party (RP) 1. The record indicated RP told the IDT that Resident 1 alleged he was hit by an unidentified male Certified Nursing Assistant (CNA). During a review of Resident 1's record titled Neuro Check Flowsheet, initiated 11/10/2025, the record indicated on 11/1/2025 at 4:45 p.m., staff started performing neuro-checks on Resident 1. a. The record indicated staff were to conduct neuro-checks every 30 minutes starting at 6:00 p.m. The record indicated RN 1 conducted the neuro-checks scheduled for: 7:00 p.m. at 8:41 p.m. (one hour and 41 minutes late) 7:30 p.m. at 8:47 p.m. (six minutes from the previous assessment) 8:00 p.m. at 8:48 p.m. (one minute from the previous assessment) 8:30 p.m. at 8:50 p.m. (two minutes from the previous assessment) b. The record indicated staff were to conduct neuro-checks every hour starting at 9:00 p.m. The record indicated RN 1 conducted the neuro-checks scheduled for: 11/10/2025 at 11:00 p.m. at 11/11/2025 at 12:04 a.m. 11/11/2025 at 12:00 a.m. at 12:06 a.m. (two minutes from the previous assessment) During an interview on 11/14/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated Resident 1 was receiving neuro-checks because a male staff allegedly hit Resident 1 on the head. The DON stated neuro-checks were to be performed at the frequency ordered and stated this was important to ensure staff were identifying any possible changes/complications as soon as possible. The DON stated that if there was a change, staff would need to notify the physician right away and carry out interventions as indicated. The DON stated RN 1 did not perform neuro-checks at the frequency and/or intervals indicated. The DON stated this was not an effective way of conducting the neuro-checks, and stated the schedule was not followed, potentially preventing timely identification of any complications. On 11/14/2025 at 3:13 p.m., an attempt was made to contact RN 1 by telephone. RN 1 did not respond to the telephone call. During a review of the facility's policy and procedure (P&amp;P) titled Neurological Assessment, undated, the P&amp;P indicated the purpose of the P&amp;P was to provide guidelines for performing neuro-checks when indicated by the resident's condition. The P&amp;P indicated staff were to perform neuro-checks at the frequency ordered.</p> |                                                                                                |                                              |