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	01/05/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor one of three sampled residents' (Resident 6) privacy.This deficient practice resulted in Resident 6 feeling frustrated and distrust in the facility to honor his privacy request.Findings:During a review of Resident 6's admission Record (Face Sheet), the admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and chronic kidney disease (progressive damage and loss of function in the kidneys). The admission Record indicated Resident 6 was self-responsible and Family Member (FM) 1 was listed as his first emergency contact.During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 11/27/2025, the MDS indicated Resident 6's cognition (process of thinking) was intact. The MDS indicated Resident 6 required supervision or touching assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 6's History and Physical (H&P), dated 10/28/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During an interview on 1/5/2026 at 9:17 a.m., with Resident 6, Resident 6 stated he previously allowed the facility to inform FM 1 about his care, however, he recently informed the nurses he no longer wanted FM 1 notified. Resident 6 stated he did not want FM 1 to know anything about his care because she lived far away, was unable to visit, and he did not want FM 1 to worry about him. Resident 6 stated he felt frustrated that the facility did not honor his request to privacy and felt distrust in the facility. During a concurrent interview and record review on 1/5/2026 at 10:59 a.m., with Registered Nurse (RN) 1, Resident 6's Progress Note, dated 12/24/2025, was reviewed. The Progress Note indicated Resident 6 expressed to RN 1 that he did not want FM 1 to know any information regarding his care. RN 1 stated, on 12/24/2025, Resident 6 approached her and informed her of his request for the facility to no longer notify FM 1 about his care. RN 1 stated Resident 6 expressed his concern for FM 1's health and did not want to bother her with his changes in conditions. During a concurrent interview and record review on 1/5/2026 at 11:04 a.m., with RN 1, Resident 6's Change in Condition Evaluation (COC), dated 1/4/2026, was reviewed. The COC indicated Resident 6 had a new onset of nasal drip, congestion, and cough. The COC indicated, on 1/4/2026 at 2:40 a.m., FM 1 was notified. RN 1 stated FM 1 should not have been notified of Resident 6's COC. RN 1 stated Resident 6 had the right to decide who was informed of his care and the nurse at the time should have honored Resident 6's request. RN 1 stated informing FM 1, after Resident 6 requested for her to be taken off as his emergency contact, went against his right to privacy and autonomy (to make own decisions). During an interview on 1/5/2026 at 3:25 p.m., with the Director of Nursing (DON), the DON stated honoring residents' right to privacy was very important. The DON stated Resident 6 had the capacity to understand and make his own decisions. The DON stated Resident 6 did not want FM 1 informed of his care and the facility should have honored his decision. The DON stated Resident 6 was (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-responsible and the licensed nurse should have asked his permission to notify his listed emergency contact. The DON stated FM 1 should have been removed from Resident 6's Face Sheet as his emergency contact to prevent any confusion and to ensure the facility notifies the correct person. The DON stated the facility did not request Resident 6's wishes.During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, undated, the P&P indicated a resident had the right to privacy and confidentiality.During a review of the facility's P&P titled, Confidentiality of Information and Personal Privacy, undated, the P&P indicated the facility would strive to protect the resident's privacy regarding his or her medical treatment and personal care.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the low air loss mattress (LALM- a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) guideline for the use of linens for one of three sampled residents (Resident 2).This deficient practice had the potential to result in worsening of Resident 2's pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and the development of new skin breakdown.Findings:During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included acute and chronic respiratory failure with hypoxia (a sudden worsening of a long-term condition where the blood oxygen levels drop severely), contracture of muscle (when a muscle becomes permanently short, tight, and stiff, making it hard or impossible to move normally), and hypertension (high blood pressure).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 9/24/2025, the MDS indicated Resident 2's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 2 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 2 used a pressure reducing device for the bed.During a review of Resident 2's History and Physical (H&P), dated 4/18/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Braden Scale, dated 11/15/2025, the Braden Scale indicated Resident 2 was at a high risk of developing pressure injuries.During a review of Resident 2's Skin Issues report, dated 12/29/2025, the Skin Issues report indicated Resident 2 had a Stage 4 pressure injury (PI, full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the rear left trochanter (hip bone area) which measured 2.25 centimeters (cm, unit of measurement) in length, 1.07 cm in width, and 0.1 cm in depth. During a review of Resident 2's Order, dated 4/18/2025, the Order indicated to use a Pressure Redistribution Optimization (P.R.O.) [NAME] Plus low air loss mattress (LALM- a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) for wound management.During an observation on 1/2/2026 at 9:24 a.m., in Resident 2's room, observed Resident 2 lying on a P.R.O. [NAME] Plus LALM. In-between the LALM and Resident 2, there was a thin white sheet, a folded white sheet, a green pad, and a disposable pad. During a concurrent observation and interview on 1/2/2026 at 11:48 a.m., in Resident 2's room, with Certified Nursing Assistant (CNA) 3, Resident 2 was observed lying on a P.R.O. [NAME] Plus LALM. In-between the LALM and Resident 2, on top of one another, there was a thin white sheet, a folded white sheet, and a disposable pad. CNA 3 stated Resident 2 was on the LALM for his wounds and she was supposed to only place a thin sheet and the disposable pad underneath the resident. CNA 3 stated she placed the extra green pad earlier to allow easier repositioning during Resident 2's wound treatment. CNA 3 stated after the treatment was over, she kept the folded white sheet under the disposable pad because Resident 2 would slide down in the bed. CNA 3 stated the folded white sheet allowed the staff to pull Resident 2 up in bed easier. CNA 3 stated, I know it is not correct; I will remove it now.During an interview on 1/2/2026 at 11:56 a.m., with Treatment Nurse (TN) 1, TN 1 stated when a resident used a LALM, only a thin sheet and a disposable pad was supposed to be underneath them. TN 1 stated the purpose of the LALM was to offload pressure along Resident 2's body. TN 1 stated if multiple layers of linen and pads were placed underneath Resident 2, the LALM would not be as effective. TN 1 stated Resident 2 had a Stage 4 PI and with the additional layers underneath him, Resident 2 was at risk of the PI worsening or new skin breakdown forming.During a concurrent interview and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review on 1/2/2026 at 2:39 p.m., with the Director of Staff Development (DSD), the facility's Lesson Plan Course Subject titled, Pressure Injury Prevention: Repositioning and Support Surface Management, dated 12/2/2025, was reviewed. The Lesson Plan indicated the course content to include linen use guidelines and avoiding excess layers that may interfere with airflow. The DSD stated part of the lesson was educating the staff to minimize the amount of linen underneath a resident on a LALM. The DSD stated CNA 3 received the education and should have followed the appropriate practice.During an interview on 1/5/2026 at 3:29 p.m., with the Director of Nursing (DON), the DON stated while Resident 2 used the LALM, the staff were educated to use minimal layers, such as a thin sheet and the disposable pad. The DON stated to maximize the LALM's pressure reducing mechanism, the less layers present would allow the LALM to offload pressure and assist with wound healing. The DON stated if Resident 2 continued to have excess layers of linen underneath him, he was at risk of delay in wound healing.During a review of the facility's document titled, User-Service Manual: Joerns Support Surfaces, P.R.O. [NAME] Plus, dated 2022, the document indicated the recommended linen was based upon the patient's specific needs, the following may be utilized: draw or slide sheet to aid in positioning and to further minimize friction and shearing [and] incontinence barrier pad for urine and/or stool and patients with heavily draining wounds.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to install bilateral (both sides) half side rails (short rails on both sides of the bed that can be used to assist in bed mobility) as ordered and provide two-person assistance prior to providing care to one of four sampled residents (Resident 5).These deficient practices resulted in Resident 5 falling off her bed on 12/26/2025.Findings:During a review of Resident 5's admission Record (Face Sheet), the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blocked blood vessel in the brain) affecting the left side, hypertension (high blood pressure), and aphasia (disorder that affects how an individual communicates) following cerebral infarction.During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 5's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 5 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, personal hygiene, and rolling left and right.During a review of Resident 5's History and Physical (H&P), dated 10/14/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions.During a review of Resident 5's Fall Risk Assessment, dated 12/25/2025, the Fall Risk Assessment indicated Resident 5 was at risk for falls. During a review of Resident 5's document titled Roll Left and Right Task, dated 12/26/2025 and timed 8:10 p.m., the document indicated Resident 5 was dependent on staff's assistance to roll left and right. The document indicated dependent was defined as the helper does all the effort where the resident does none of the effort to complete the activity or the assistance of two or more helpers was required for the resident to complete the activity.During a review of Resident 5's Change in Condition Evaluation (COC), dated 12/26/2025, the COC indicated, on 12/26/2025 at approximately 9 p.m., Certified Nursing Assistant (CNA) 4 was providing incontinence care (changing individual's diaper and cleaning the area) and repositioned Resident 5 onto her right side. During the brief change, Resident 5 began to shift and slide, causing the upper portion of her body to roll toward the floor. CNA 4 immediately assisted Resident 5 to the floor in a controlled manner to prevent injury.During an interview on 1/2/2026 at 3:05 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, on 12/26/2025, CNA 4 informed her Resident 5 rolled off the bed. LVN 2 stated CNA 4 assisted Resident 5 by herself. LVN 2 stated she assessed Resident 5 and Resident 5 did not have any visible physical injuries and did not deviate from her baseline. LVN 2 stated Resident 5 required two-person assistance in repositioning. During an interview on 1/5/2026 at 11:13 a.m., with Registered Nurse (RN) 1, RN 1 stated on 12/26/2025, she was made aware CNA 4 repositioned Resident 5 and changed her diaper by herself. RN 1 stated CNA 4 repositioned Resident 5 to the side and the resident went over the bed.During a concurrent interview and record review on 1/5/2026 at 11:16 a.m., with RN 1, Resident 5's Care Plan titled, Activities of Daily Living Self-Care Deficit, initiated 10/13/2025, was reviewed. The Care Plan's indicated Resident 5 required two staff participation to reposition and turn in bed. RN 1 stated Resident 5 required a two-person assist because Resident 5 was dependent on staff's assistance and was unable to make any of the effort. RN 1 stated when Resident 5 was repositioned on her side, she was unable to hold herself up or keep herself from rolling over the edge of the bed, therefore having another person on the opposite side of the bed was necessary to ensure safety. RN 1 stated Resident 5's fall could have been avoided if a second person was on the opposite side of the bed to provide additional support. During an interview on 1/5/2026 at 3:13 p.m., (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with CNA 4, CNA 4 stated prior to Resident 5's fall on 12/26/2025, she was able to reposition and change Resident 5's diaper on her own with no issues. CNA 4 stated she never had issues positioning Resident 5 in bed, therefore continued to provide care on her own. CNA 4 stated, on 12/26/2025, she positioned Resident 5 on her side to place the diaper underneath her and Resident 5 began to roll off the bed. CNA 4 stated when Resident 5 began to roll off the bed, she lowered the bed to the floor and assisted Resident 5 to the floor. CNA 4 stated she then informed LVN 2 who came to the bedside to assess Resident 5. CNA 4 stated Resident 5 did not have any side rails on the bed. CNA 4 stated she should have checked Resident 5's Kardex (a quick-reference resident information system) for the level of assistance Resident 5 required during care. CNA 4 stated if she checked Resident 5's Kardex, she would have known Resident 5 required a two-person assist. CNA 4 stated, on 12/26/2025, she should have asked for assistance to provide additional safety precautions when repositioning Resident 5.During an interview on 1/5/2026 at 3:31 p.m., with the Director of Nursing (DON), the DON stated Resident 5 required two-person assist in bed mobility and repositioning. The DON stated CNAs should always check the resident's Kardex to ensure all safety precautions were in place. During a concurrent interview and record review on 1/5/2026 at 3:35 p.m., with the DON, Resident 5's Orders, order dated 10/14/2025, was reviewed. The Orders indicated to apply bilateral half side rails to enhance bed mobility and repositioning. The DON stated Resident 5 had an order to utilize side rails. The DON stated the purpose of the side rails would allow Resident 5 to grab onto to role to one side and reposition safely. The DON stated on 12/26/2025, CNA 4 positioned Resident 5 to her side and the resident began to roll off the bed. The DON stated precautions were not in place to safely reposition Resident 5. The DON stated Resident 5's fall, on 12/26/2025, could have been prevented if a second person was present to assist and if the ordered side rails were in place. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance.During a review of the facility's P&P titled, Repositioning, revised 5/2013, the P&P indicated, Check the care plan, assignment sheet, or the communication system to determine resident's specific positioning needs including specific equipment, resident level of participation, and the number of staff required to complete the procedure.