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	03/26/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Change in a Resident's Condition or Status, which indicated the nurse would notify the resident's attending physician (PCP) for changes in condition for one of three sampled residents (Resident 2) when:Registered Nurse (RN) 1 identified a discoloration/bruise to Resident 2's left hip area on 3/14/2026. Resident 2 alleged that on 3/14/2026, she was hit by a Certified Nurse Assistant (CNA).This failure had the potential to result in delayed medical care for Resident 2 and had the potential to negatively affect the resident's psychological and physical well-being. Cross Reference F842Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included fracture (broken bone) of right femur (thighbone), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and anxiety disorder (mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life).During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/17/2026, the MDS indicated Resident 2 had severe cognitive impairments (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, showering/bathing self and bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 2's Change of Condition (COC), dated 3/14/2026, the COC indicated Resident 2 reported an allegation of abuse and the PCP was notified on 3/14/2026 at 4:24 p.m. The COC did not indicate a full body (head-to-toe) assessment was done after the facility was made aware of the allegation. The COC did not Resident 2 had a discoloration/bruise or that the PCP was notified about the bruise. During interview on 3/25/2026 at 3:45 p.m. and 3/26/2026 at 3:29 p.m., with RN 1, RN 1 stated he performed a full body assessment on Resident 2 after the resident alleged that during a shower on 3/14/2026, a CNA hit her on the head. RN 1 stated he found a finger-length bluish discoloration to Resident 2's hip on 3/14/2026. RN 1 stated the skin assessment was not placed in Resident 2's medical records and was recorded on a separate paper skin assessment form as part of the abuse investigation file. RN 1 stated he could not reach Resident 2's PCP regarding the resident's allegation of abuse and skin discoloration identified on 3/14/2026. RN 1 stated he should have informed the Medical Director when attempts to notify the PCP failed, to ensure Resident 2's skin did not worsen and because any changes and allegations of abuse should have been reported to the PCP.During a concurrent interview and record review on 3/26/2026 at 4:40 p.m., with the Director of Nursing (DON), Resident 2's COC and skin assessment, dated 3/14/2026 were reviewed. The DON stated a head-to-toe skin assessment should be completed for all allegations of abuse, and the PCP should be notified if there were any skin discolorations identified. The DON stated staff should contact the Medical Director if they were unable to get a hold of the PCP. During a review of facility's P&P titled, Change in a Resident's Condition or Status, undated, the P&P (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(n): accident or incident involving the resident.During a review of facility's P&P titled, Abuse and Neglect - Clinical Protocol, dated 2018, the P&P indicated, The nurse will assess the individual and document related findings, and indicated, Assessment data will include injury assessment. The P&P also indicated, The nurse will report findings to the physician.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Bed-Hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital [GACH] in anticipation of their return to the facility) written notification as indicated in its policy and procedure (P&P) titled, Bed-Holds and Returns to one of three residents (Resident 3), who was transferred to the GACH on 3/10/2026.This failure had the potential to violate Resident 3's right to a bed-hold and result in the resident's inability to return to his home at the facility. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included respiratory failure (a serious condition that makes it difficult to breath on your own) with hypoxia (low levels of oxygen in the body's tissues).During a review of Resident 3's History and Physical (H&P), dated 2/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 3 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, shower/bathe self and bed mobility (ability to roll from lying on back to left and right side, and return to lying on back on the bed).During a review of Resident 3's Discharge summary, dated [DATE], the Discharge Summary indicated Resident 3 was transferred to the GACH for a Gastrostomy Tube ([G-tube], a small tube placed through the belly into the stomach to provide food, fluids, and medicine directly to someone who cannot eat enough by mouth) replacement.During a review of Resident 3's, Bed-hold Informed Consent/Notification Form (Bed-hold notice), dated 2/21/2026, the form did not indicate that a Notice of Bed-hold was provided to Resident 3's responsible party (RP) after Resident 3 was transferred to the GACH on 3/10/2026.During an interview on 3/26/2026 at 2:47 p.m., with the Business Office Manager (BOM), the BOM stated that the nursing department was responsible for providing the Bed-hold Notice to the residents or RP.During a concurrent interview and record review on 3/26/2026 at 4:18 p.m., with the Director of Nursing (DON), Resident 3's Bed-hold Notice dated 2/21/2026, and facility's undated P&P titled, Bed-Holds and Returns, were reviewed. The DON stated residents' beds should be held for 7 days when they are transferred to the GACH and staff would verbally inform the RPs regarding the bed-hold at the time of transfer. The DON stated she was not aware that any written notices should be provided to RPs. The DON stated according to the facility P&P, a written second notice should have been provided to Resident 3's RP at the time of transfer on 3/10/2026 and the facility did not follow this P&P. The DON stated that by not providing the bed-hold notice, Resident 3s RP might not be aware Resident 3 was able to return after hospitalization. During a review of facility's undated P&P titled, Bed-Holds and Returns, the P&P indicated, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice:Notice 1: well in advance of any transfer (e.g., in the admission packet); andNotice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate clinical medical records, for one of three sampled residents (Resident 2) by failing to:Ensure Registered Nurse (RN) 1 documented Resident 2's full body (head-to-toe) assessment and skin discoloration/bruise identified on 3/14/2026 in the resident's medical records.Ensure RN 1 did not document a recommendation of PCP (Primary Care Physician) in Resident 2's Change in Condition (COC) form without speaking with the PCP. This deficient practice had the potential to result in miscommunication between staff and a delay in the provision of care or interventions for Resident 2. Cross Reference F580Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included fracture (broken bone) of right femur (thighbone), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and anxiety disorder (mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life).During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/17/2026, the MDS indicated Resident 2 had severe cognitive impairments (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, showering/bathing self and bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 2's Change of Condition (COC), dated 3/14/2026, the COC indicated Resident 2 reported an allegation of abuse. The COC indicated Resident 2's PCP was notified on 3/14/2026 at 4:24 p.m. The COC indicated a recommendation of PCP included to Monitor for pain and episodes of sadness/depression post 72 hours. The COC did not indicate a full body assessment was completed. The COC did not indicate Resident 2 had any discoloration/bruise. During an interview on 3/25/2026 at 3:45 p.m., with RN 1, RN 1 stated he performed a full body assessment on Resident 2 after the resident alleged that during a shower on 3/14/2026, a Certified Nurse Assistant (CNA) hit her on the head. RN 1 stated he found a finger length bluish discoloration to Resident 2's hip on 3/14/2026. RN 1 stated the skin assessment was not placed in Resident 2's medical records and was recorded on a separate paper skin assessment form as part of the abuse investigation file.During a review of Resident 2's skin assessment (submitted for the abuse investigation file), dated 3/14/2026, the skin assessment indicated Resident 2 was had a bruise to the left hip area.During a subsequent interview on 3/26/2026 at 3:29 p.m., with RN 1, RN 1 stated he could not reach Resident 2's PCP regarding the resident's allegation of abuse on 3/14/2026. RN 1 stated Resident 2's COC was incorrect and the recommendation to Monitor for pain and episodes of sadness/depression, should not have been documented.During a concurrent interview and record review on 3/26/2026 at 4:40 p.m., with the Director of Nursing (DON), Resident 2's COC and skin assessment, dated 3/14/2026 were reviewed. The DON stated if staff did not get a hold of the PCP, the PCP recommendation on the COC should have been left blank and attempts to reach the PCP should have been documented in the progress notes. The DON stated that Resident 2's COC also did not indicate that a bruise was found during the nurse's skin assessment on 3/14/2026.During a subsequent interview on 3/31/2026 at 3:10 p.m., with the DON, the DON stated a COC should include pertinent information including changes found during a full body assessment and should have been part of the resident's medical records so staff could notify the PCP and to obtain any new orders needed to treat changes to the resident's condition.During a review of facility's P&P titled, Charting and Documentation, dated 7/2017, the P&P indicated Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The P&P also indicated, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation of procedures and treatments will include care-specific details, including the assessment data and/or any unusual findings obtained during the procedure/treatment and notification of family, physician or other staff, if indicated.