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	05/19/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plan interventions were documented every shift for one out of three sampled residents (Resident 1) who was identified as a fall risk. This deficient practice resulted in Resident 1 suffering a fall on 5/5/2026 and sustaining a fracture (broken bone) to the right medial orbital wall (thin bone separating the eye socket from the sinuses). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included cerebral infarction (ischemic stroke, occurs when a blood vessel in the brain becomes blocked or severely narrowed), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (partial weakness or the inability to move one entire side of the body), aphasia (a disorder that makes it difficult to speak), gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 1's cognitive skills for daily decision making were severely impaired (ability to think and reason). The MDS indicated Resident 1 was dependent on staff for bed mobility and activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Fall Risk Assessment, dated 1/14/2026, the assessment indicated Resident 1 was at risk for falls. During a record review of Resident 1's Change of Condition Note, dated 5/5/2026, the note indicated on 5/5/2026, Resident 1 was observed lying on the floor mat on the right side of the bed in a right-side lying position. The note indicated Resident 1 was noted with bleeding to the right eye and a laceration (a jagged tear or cut in the skin) below the eyebrow. During a record review of Resident 1's General Acute Care Hospital (GACH) Computed Tomography (CT, a type of medical imaging) Results, dated 5/5/2026, the GACH CT results indicated Resident 1 had a right medial orbital wall fracture (a break in the thin bone separating the eye socket from the sinuses). During a concurrent interview and record review on 5/19/2026 at 8:46 a.m. with Registered Nurse (RN) 2, Resident 1's care plan, titled At Risk for Fall, initiated 11/26/2025, and Nursing Progress Notes, dated 4/2026 through 5/5/2026, were reviewed. The care plan indicated to ensure Resident 1's bed was in low position, wedges were in place for proper positioning, and correct placement and positioning of bilateral (both) floor mats were at the bedside. The Nursing Progress Notes did not indicate, from 4/11/2026 and 5/5/2026, Resident 1's floor mats and wedges were checked for placement and that the bed was kept in a low position. RN 2 stated documentation should have been completed by her or the nursing staff to ensure all fall precautions were in place on a shift-to-shift basis to minimize the chance of injury due to a fall. RN 2 stated the implementation of the care plan interventions could not be verified due to the lack of documentation. RN 2 stated if fall precautions were not maintained and documented, there was a potential for Resident 1 to fall and sustain an injury. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered (undated), the P&P indicated the facility would ensure a (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. During a review of the facility's P&P titled, Charting and Documentation (undated), the P&P indicated the facility would ensure all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, would be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.