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	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure opened and refrigerated soup was disposed of within three days, and frozen hashbrowns were covered and sealed for 104 medically compromised and vulnerable residents who received food from the kitchen.These deficient practices had the potential to place residents at risk for foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins).Findings:During a concurrent observation and interview on 6/1/2026 at 8:50 a.m. with the Dietary Supervisor (DS) in the kitchen, a container labeled chicken noodle soup 5/25/2026 was observed in the refrigerator. The DS stated the chicken noodle soup should not have been in the refrigerator and should have been discarded three days after being opened. An opened bag of hashbrown potatoes was observed in the freezer, not fully closed. The DS stated the bag should have been sealed The DON stated the potatoes appeared freezer burned (when frozen foods are exposed to cold, dry air, causing them to dehydrate, often resulting in ice crystal formation on the outside of food). The DS stated food should be disposed of and stored according to facility policy to preserve food integrity and prevent foodborne illnesses.During an interview on 6/4/2026 at 11:29 a.m. with the Director of Nursing (DON), the DON stated kitchen staff should ensure foods were stored according to facility policy. The DON stated failure to properly store and dispose of food placed residents at risk for foodborne illnesses.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage revised 11/2022, the P&P indicated, All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). The P&P indicated, Frozen foods are maintained at a temperature to keep the frozen food solid. Wrappers of frozen foods must stay intact until thawing.During a review of the facility's P&P titled, Refrigerated Food Items revised 1/16/2024, the P&P indicated refrigerated soups should be disposed of within 2-3 days.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate respiratory monitoring, documentation, and assessments were completed, and oxygen signage was posted for one of three sampled residents (Resident 11) when the facility failed to ensure:a. Resident 11's oxygen administration was documented.b. Resident 11's Oxygen saturation (O2 sat- measurement of percentage of oxygen in your blood) was monitored every shift.c. Resident 11's oxygen care plan was developed to address Resident 11's continuous oxygen use.d. Display a No Smoking/Oxygen in Use sign at a resident room entrance where an oxygen concentrator (a medical device that provides oxygen-enriched air to help people breathe) was in use.These deficient practices had the potential to place Resident 11 at risk of delayed assessment, identification of respiratory complications, and delayed care. This deficient practice also had the potential to place all 132 residents residing in the facility, visitors, and staff at risk of a fire hazard.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 11's diagnoses included pneumonia (an infection/inflammation in the lungs), schizophrenia (a mental illness that is characterized by disturbances in thought), and dementia (a progressive state of decline in mental abilities).During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 11's cognitive (ability to think and understand) skills for daily decision making was severely impaired. The MDS indicated Resident 11 was dependent on staff for toileting, bathing, and dressing.During a review of Resident 11's Change in Condition (COC) Evaluation, dated 5/23/2026, the COC Evaluation indicated Resident 11 developed a productive cough (cough that brings up mucus or phlegm from the lungs and airways). Resident 11's physician recommended oxygen administration at three liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen), as needed (PRN) breathing treatments, a chest X-ray and antibiotic therapy (used to treat and prevent bacterial infections).During a review of Resident 11's physician's orders dated 5/23/2026, the physician orders indicated to administer oxygen at four liters per minute via nasal cannula as needed for an O2 saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) less than 95 percent (%).During an observation on 6/1/2026 at 10:05 a.m., Resident 11 was observed receiving three liters of continuous oxygen via nasal cannula.a. During a concurrent interview and record review on 6/3/2026 at 12:49 a.m. with Licensed Vocational Nurse (LVN) 5, Resident 11's Medication Administration Record (MAR- document used to track all medications administered to a resident) dated May through June of 2026 was reviewed. The MAR did not indicate Resident 11 was administered oxygen. LVN 5 stated the licensed nurse that administered oxygen to Resident 11 should have documented the oxygen administration in the MAR. LVN 5 stated lack of documentation placed Resident 11 at risk of improper monitoring. LVN 5 stated residents clinical records should accurately reflect the medications and treatments they received.During an interview on 6/3/2026 at 1:06 p.m. with Registered Nurse (RN) 1, RN 1 stated licensed nurses were expected to document every medication and treatment administered to residents. RN 1 stated failure to document Resident 11's oxygen administration placed the resident at risk for inconsistent nursing care and inadequate respiratory monitoring and assessments.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration last revised 2/2024, the P&P indicated documentation of oxygen administration is to include the signature and title of the person recording the data.b. During a concurrent interview and record review on 6/3/2026 at 9:20 a.m. with LVN 5, Resident 11's Weights and Vitals Summary dated June 2026 were reviewed. Resident 11's Weights and Vitals summary did not indicate Resident 11's oxygen saturation was monitored and documented. LVN 5 stated Resident 11's oxygen saturation should have been checked every shift to ensure the O2 sat parameter of 95% was being met and monitored. LVN 5 stated failure to monitor Resident 11's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen saturation placed the resident at risk for delayed care and identification of respiratory complications.During a concurrent interview and record review on 6/3/2026 at 1:06 p.m. with RN 1, Resident 11's physician orders indicated there were no orders to check Resident 11's O2 sat every shift. RN 1 stated residents receiving continuous oxygen should have orders to check the O2 sat every shift to ensure the resident was meeting the parameters, and to titrate (adjusting the amount of supplemental oxygen a patient receives, either increasing or decreasing the flow rate, to reach and maintain a specific target blood oxygen level) the oxygen if needed. RN 1 stated not monitoring Resident 11's O2 sat every shift placed resident at risk for respiratory complications such as unaddressed respiratory distress, delayed identification and treatment.c. During a concurrent interview and record review on 6/3/2026 at 9:20 a.m. with LVN 5, Resident 11's medical records were reviewed. The records did not indicate a care plan was developed that addressed Resident 11's continuous oxygen use. LVN 5 stated an oxygen care plan should have been created because the interventions guide nursing care, respiratory assessments, and special precautions required for each resident. LVN 5 stated failure to develop an oxygen care plan placed Resident 11 at risk for inadequate respiratory assessments and monitoring.During an interview on 6/4/2026 at 9:32 a.m. with the DON, the DON stated care plans should be comprehensive and provide specific interventions to address resident needs. The DON stated oxygen care plans were important because they provided the respiratory assessments nursing staff should be completing. The DON stated lack of care plan placed Resident 11 at risk for delayed identification of respiratory complications, interventions, and physician notification.d. During a concurrent observation and interview on 6/1/2026 at 10:10 a.m. with LVN 2, outside of Resident 11's room, Resident 11's room entrance was observed without a No smoking/Oxygen in use sign. Resident 11 was observed lying in bed with an oxygen concentrator at the bedside. LVN 2 stated there should be a No smoking/Oxygen in use sign on Resident 11's door to ensure no open flames or smoking took place near Resident 11's room. LVN 2 stated lack of signage placed residents, visitors, and staff at risk of a fire hazard.During an interview on 6/4/2026 at 9:32 a.m. with the DON, the DON stated all residents on continuous oxygen should have a No smoking/Oxygen in use sign on their door to ensure resident safety and prevention of fire in the facility.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered last revised 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.During a review of the facility's P&P titled, Oxygen Administration last revised 2/2024, the P&P indicated, Review the resident's care plan to assess for any special needs of the resident. The P&P indicated No smoking signs were necessary for oxygen administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the medication refrigerator within the required temperature range for the storage of medications intended for resident use in one of one medication refrigerators reviewed.This deficient practice had the potential to compromise the stability, potency, and effectiveness of stored medications, placing residents at risk of receiving medications that may not provide the intended therapeutic effect and potentially adversely affecting their health and safety.Findings: During a concurrent observation and interview on 6/2/2026 at 12:40 p.m., with Licensed Vocational Nurse (LVN) 4, in Medication room [ROOM NUMBER], LVN 4 stated that the refrigerator was designated for storing newly received medications that required refrigeration before resident use. Upon opening the refrigerator, the internal thermometer displayed a temperature of 28 degrees Fahrenheit (a temperature scale). The refrigerator temperature log, which was attached to the front of the refrigerator door, indicated that the acceptable storage temperature range was between 36 and 46 degrees Fahrenheit. During the observation, three emergency medication kits labeled Keep Refrigerated were stored inside the refrigerator along with one other vial of medication. The following was observed:a. Each emergency kit contained one Novolin Regular insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection pen containing 3 milliliters (mL- a measurement of volume) of insulin, one Humalog Lispro insulin injection pen containing 3 mL of insulin, and two 1 mL vials (glass container) of lorazepam (antianxiety medication). b. One vial of 1 ml of Procrit (medication used to treat anemia caused by chronic kidney disease) with pharmacy labeling stating that the medication must be refrigerated and Do Not Freeze.LVN 4 stated that a temperature of 28 degrees Fahrenheit was below the freezing point. LVN 4 stated the medications stored in the refrigerator were at risk of freezing. LVN 4 stated that refrigerated medications, particularly insulin and other temperature-sensitive medications, must be maintained within the recommended temperature range to preserve their stability, potency, and therapeutic effectiveness. LVN 4 stated that if these medications freeze, they may become ineffective or unsafe for administration and would require replacement before resident use. LVN 4 stated that licensed nursing staff were responsible for monitoring and documenting refrigerator temperatures each day and ensuring that medications were stored according to pharmacy recommendations. LVN 4 stated that when a refrigerator temperature falls outside the acceptable range, the medications should be immediately assessed, removed from use if necessary, and the issue promptly reported to the Director of Nursing and the maintenance supervisor so corrective action can be taken.During a concurrent observation and interview on 6/2/2026 at 12:48 p.m., with the Director of Maintenance (DOM), the DOM observed the medication room refrigerator thermometer displaying a temperature below the facility's recommended range of 36 F to 46 F. The DOM stated that the temperature was not within the acceptable range for medication storage. The DOM stated that the refrigerator had been set to a freezing level rather than the appropriate refrigeration setting, causing the internal temperature to fall below the recommended range. The DOM stated that medications requiring refrigeration should be maintained within the recommended temperature. The DOM stated that the refrigerator settings should have been routinely monitored appropriately and adjusted as needed to ensure compliance with medication storage requirements.During an interview on 6/3/2026 at 12:47 p.m., with the Director of Nursing (DON), the DON stated that medications requiring refrigeration must be stored and maintained within the pharmacy's recommended temperature range of 36 F to 46 F to ensure medication integrity, potency, and effectiveness. The DON stated that nursing staff were responsible for monitoring and documenting refrigerator temperatures each day and for immediately reporting and addressing any temperature readings that (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fall outside the acceptable range. The DON stated that a refrigerator temperature below the recommended range could expose medications to freezing conditions, potentially compromising their stability and therapeutic effectiveness. The DON stated that the refrigerator should have been adjusted as soon as the out-of-range temperature was identified and that medications stored under improper temperature conditions should be evaluated according to facility policy and pharmacy guidance before being administered to residents. The DON stated that maintaining appropriate medication storage conditions was essential to ensure safe medication administration, medication patency and protect resident health and safety.During a review of the facility's policies and procedure (P&P) titled Medication Labeling and Storage dated 2/2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 73) was informed of the reason for being restricted from the nursing station. This deficient practice had the potential to violate Residents 73's rights, and potentially cause emotional distress and feelings of disrespect, resulting in a loss of dignity and self-worth.Findings:During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was originally admitted on [DATE] and readmitted on [DATE]. Resident 73 diagnoses included type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), left acetabulum fracture (a broken part of the left hip socket that helps hold the leg bone in place), and bilateral hearing loss.During a review of Resident 73's Minimum Data Set (MDS- a resident assessment tool), dated 5/6/2026, the MDS indicated Resident 73's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 73 required moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 73's had moderate difficulty (speaker must increase volume to speak) hearing. During an interview on 6/4/2026 at 8:12 a.m., with Resident 73, Resident 73 stated he did not matter at the facility because he was not told why he could not go to the nurses' station. Resident 73 stated he felt ignored and waws denied information about decisions affecting him.During an interview on 6/4/2026 at 10:45 a.m., with the Assistant Director of Nursing (ADON), the ADON stated residents have the right to be informed about decisions affecting them and deserve a clear explanation. The ADON stated failure to do so may cause residents to feel ignored, devalued, and that they do not belong or matter at the facility, negatively affecting their trust and emotional well-being.During a telephone interview on 6/4/2026 at 4:13 p.m., with Registered Nurse (RN) 3, RN 3 stated residents should be treated with dignity and kept informed. RN 3 stated without explanation, residents may feel excluded, unimportant, and that their concerns were not valued.During a telephone interview on 6/4/2026 at 4:22 p.m., with RN 1, RN 1 stated residents should be treated with respect and dignity to prevent them from feeling unwanted or insignificant. RN 1 stated unclear communication could make residents feel left out, undervalued, and as though their concerns were not acknowledged.During a telephone interview on 6/4/2026 at 4:29 p.m., with the Director of Staff Development (DSD), the DSD stated residents should be treated with kindness and have the right to be informed. The DSD stated residents without explanations may feel ignored, silenced, and their concerns disregarded.During a review of the facility's policy and procedures (P&P) titled Resident Rights undated, the P&P indicated employees must always treat residents with kindness, respect, and dignity. The P&P indicated, residents should be cared for, communicated with, and given access to people and services inside and outside the facility.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled Psychotropic Medication Use/Informed Consent dated 3/2024, for two of seven sampled residents (Resident 14 and Resident 56) when the facility failed to ensure:1. Resident 14's informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained for Depakote (a psychotropic medication that affect the mind, emotions, and behavior) prior to initiation.2. Resident 56's informed consent for Duloxetine (used to treat depression, generalized anxiety disorder, and various forms of chronic pain) was updated with the correct indication.These deficient practices had the potential to result in Residents 14 and 56's rights not being honored by not being able to participate in care and be fully informed of psychotropic (drugs that treat mental health disorders, affecting mood, thoughts, and behaviors) medication use. Findings: a. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), epilepsy (a neurological disorder characterized by recurrent, unprovoked seizure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool), dated 8/17/2025, the MDS indicated Resident 14's cognition (the ability to think and process information) was intact. The MDS indicated Resident 14 required moderate (helper does less than half the effort) assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 14 received antipsychotic medication (a class of psychiatric medications primarily prescribed to manage psychosis, including delusions, hallucinations, paranoia, and confused thinking). During a review of Resident 14's History and Physical (H&P), dated 10/4/2025, the H&P indicated Resident 14 had the capacity to understand and make decisions. During a review of Resident 14's physician order, dated 3/19/2026, the physician order indicated to administer Depakote 500 milligrams (mg, a unit of dose measurement), one tablet by mouth two times a day for seizure. During a concurrent interview and record review on 6/3/2026 at 1:19 p.m., with Registered Nurse (RN) 1, Resident 14's physician order for Depakote dated 3/19/2026, was reviewed. The physician order did not indicate informed consent was obtained from Resident 14 prior to the initiation of Depakote. RN 1 stated that psychotropic medication such as Depakote required informed consent prior to initiation of the treatment to ensure the resident understand the risks, benefits and potential side effects. RN 1 stated failure to obtain an informed consent for Depakote placed Resident 14 at risk for receiving a psychotropic medication without being fully informed, without knowledge and without the opportunity to participate in the decision regarding the treatment. RN 1 stated it was the licensed staff's responsibility to ensure that informed consent for psychotropic medication was obtained and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintained in the resident's medical record. b. During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 56's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (an excess of lipids or fats in your blood) and chronic kidney disease (CKD-kidney damage effecting its ability to filter blood). During a review of Resident 56's H&P dated 5/1/2026, the H&P indicated Resident 56 had limited decision making capacity. During a review of Resident 56's MDS dated [DATE], the MDS indicated Resident 56 had severe cognitive impairment. The MDS indicated Resident 56 required substantial staff assistance for toileting, dressing and personal hygiene. During a review of Resident 56's physician's order dated 10/15/2025, the order indicated to administer Duloxetine Hydrochloride (medication used to help regulate mood and block pain signals) oral capsule delayed release particle 20 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), by mouth one time a day for depression as evidenced by expressing sadness. During a review of Resident 56's informed consent for duloxetine dated 10/28/2025, the informed consent indicated the indication for use was for depression as evidenced by expressing sadness. During a review of Resident 56's physician's order dated 11/1/2025, the order indicated to administer Duloxetine Hydrochloride oral capsule delayed release particles 20 mg, one capsule, by mouth one time a day for pain management history of diabetic neuropathy (nerve damage caused by long-term high blood sugar associated with diabetes). During a review of Resident 56's informed consent for duloxetine dated 4/28/2026, the informed consent did not indicate an indication for use. During a concurrent interview and record review on 6/3/2026 at 3:49 p.m. with the Assistant Director of Nursing (ADON), Resident 56's psychiatric follow up note dated 10/31/2025 and informed consent for duloxetine dated 4/28/2026 was reviewed. Resident 56's psychiatric follow up note indicated duloxetine indication was changed to pain management for diabetic neuropathy. The ADON stated another consent should have been obtained when the indication for duloxetine changed. The ADON stated the informed consent for duloxetine dated 4/28/2026 did not include an indication at all, and should have. The ADON stated updating informed consents to include the correct indication was important because it was the residents right to be included in the planning process and fully informed of all psychotropic medications they were prescribed. During an interview on 6/4/2026 at 9:32 a.m. with the Director of Nursing (DON), the DON stated it was the residents right to be aware of the indication of each psychotropic medication they were prescribed. The DON stated Resident 56's informed consent should have the correct indication, and should have been updated when the indication changed. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use/Informed Consent, dated 3/2024, the P&P indicated prior to initiating treatment with psychotherapeutic drugs, facility staff must verify the resident health record contains written informed consent with the required signatures. The P&P indicated Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: indications for use.

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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 ensure the physician was notified in a timely manner of a resident's repeated refusal of a prescribed medication and an ordered ammonia (a blood test used to measure the amount of ammonia [a waste product] in the blood) level laboratory test for one of two sampled residents (Resident 40). This deficient practice resulted in Resident 40's physician not being informed of Resident 40's repeated refusals, and placed Resident 40 at risk for delayed assessment, delayed intervention, treatment, unmanaged change of condition, and potential adverse outcomes related to lack of physician oversight of the laboratory monitoring. Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE]. Resident 40's diagnoses included dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and heart failure (heart muscle is too weak to pump enough blood and oxygen to meet your body's needs). During a review of Resident 40's Minimum Data Set (MDS- a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 40's cognitive skills for daily decision making (the ability to think and process information) was moderately impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for 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 40's History and Physical (H&P) dated 7/1/2025, the H&P indicated Resident 40 had fluctuating (change frequently) capacity to understand and make decisions. During a review of Resident 40's physician's order, dated 9/5/2025, the physician's order indicated to administer Midodrine (used to treat orthostatic hypotension (a sudden, severe drop in blood pressure when you stand up)) 10 milligrams (mg, a unit of dose measurement), one tablet by mouth three times a day for hypotension (low blood pressure). During a review of Resident 40's physician's order, dated 10/9/2025, the physician's order indicated to administer Divalproex Sodium (an anticonvulsant [mood stabilizer] medication) 125 mg, two capsules by mouth two times a day for mood swings and continuous yelling. During a review of Resident 40's physician's order, dated 1/22/2026, the physician's order indicated to collect an ammonia (a blood test used to measure the amount of ammonia [a waste product] in the blood) level laboratory test. During a review of Resident 40's facility's consultant pharmacist's Medication Regiment Review (MRR-a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication, to the physician), dated 5/1/2026 to 5/11/2026, the MRR indicated a recommendation for an ammonia level due to Resident 40 receiving Divalproex Sodium. The MRR did not indicate the physician was notified of the pharmacist's recommendation. During a concurrent interview and record review on 6/2/2026 at 1:20 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 40's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/2026 through 5/31/2026, was reviewed. The MAR did not indicate Resident 40's refusal of Midodrine on 5/26/2026, 5/27/2026, and 5/28/2026. LVN 3 stated Resident 40 refused the medication three consecutive days. LVN 3 stated the licensed nurse was responsible for accurately documenting on the progress note and notifying the resident's physician. During a concurrent interview and record review on 6/2/2026 at 1:30 p.m., with LVN 3, Resident 40's progress notes dated 5/20/2026 through 5/31/2026, was reviewed. Resident 40's progress notes did not indicate documented evidence indicating the physician was notified of Resident 40's refusal of Midodrine on 5/26/2026, 5/27/2026, and 5/28/2026. LVN 3 stated the physician should have been notified when Resident 40 refused the medication three consecutive days. LVN 3 stated the physician needed to be informed to evaluate the reason for the resident's repeated (continued on next page)

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Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusal, assess the resident's clinical condition, and determine whether additional interventions, monitoring, or changes to the treatment plan were necessary. During a concurrent interview and record review on 6/3/2026 at 2:30 p.m., with the Director of Nursing (DON), Resident 40's progress notes, dated 5/20/2026 through 5/31/2026, was reviewed. The progress notes indicated Resident 40 refused the ammonia level on 5/20/2026 through 5/25/2026. The DON stated Resident 40's progress notes indicated the resident refused laboratory tests five consecutive days. The DON stated Resident 40's repeated refusal of the laboratory test should have been communicated to the physician. The DON stated physician notification was necessary so the physician was aware of the resident's continued refusal and to evaluate the resident's condition, discuss alternative approaches, determine whether the ammonia level laboratory test remained necessary, and provide further orders as appropriate. The DON stated failure to obtain the ordered ammonia level laboratory test and failure to notify the physician of Resident 40's repeated refusals could delay the physician's ability to assess the effectiveness and safety of the resident's medication regimen. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the facility must notify the resident's physician of changes in the resident's medical, mental condition, including refusal of treatment or medications two or more consecutive times.

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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 observation, interview, and record review, the facility failed to ensure comprehensive care plans were developed for three of three sample residents (Resident 84, Resident 53, and Resident 40) addressing the following:1. Resident 84's use of oxygen therapy.2. Resident 53's use of pioglitazone (medication used to help lower blood sugar), metformin (medication used to help lower blood sugar), and glargine (medication given by injection that helps lower blood sugar).3. Resident 40's use of midodrine (medication used to raise blood pressure).These deficient practices had the potential to place Residents 84, 53, and 40 at risk for complications related to breathing, blood sugar control, and blood pressure management due to unmet care needs, inadequate monitoring of treatment, and lack of established therapeutic goals.Findings: 1. During a review of Resident 84's admission Record, the admission Record indicated, the facility admitted Resident 84 on 5/20/2022 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), pleural effusion (excess fluid in the space between your lungs and the inside of your chest wall), chronic pulmonary edema (buildup of excess fluid in the tiny air sacs of in the lungs), and asthma (lung condition where the airways swell, tighten, and fill with mucus). During a review of Resident 84's History and Physical (H&P), dated 5/15/2026, the H&P indicated Resident 84 can make needs known but can not make medical decisions. During a review of Resident 84's Minimum Data Set (MDS - a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 84 had shortness of breath or trouble breathing when lying flat. The MDS indicated Resident 84 received intermittent oxygen therapy on admission and while a resident. During an observation on 6/1/2026 at 1:10 p.m. in Resident 84's room, Resident 84 was observed lying in bed. Resident 84 was receiving 4 liters (L – metric unit of measurement, used for measuring the volume of liquids or gases) of oxygen through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). During an observation on 6/2/2026 at 10:50 a.m. in Resident 84's room, Resident 84 was observed lying in bed, receiving 4 L of oxygen through a nasal cannula. During a concurrent interview and record review on 6/2/2026 at 11:03 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 84's medical records was reviewed. The records did not indicated a care plan was developed for Resident 84's oxygen use. LVN 1 stated, Resident 84 was at risk for inappropriate oxygen use because the nursing staff would not be able to determine if the oxygen therapy was effective in achieving Resident 84's oxygen goals or whether interventions should be continued, modified, or discontinued without a care plan. During a concurrent interview and record review on 6/2/2026 at 12:56 p.m. with the Director of Nursing (DON), Resident 84's care plan was reviewed. The DON stated, Resident 84 should have a care plan when receiving oxygen therapy. 2. During a review of Resident 53's admission Record, the admission Record indicated Resident 53 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was admitted to the facility on [DATE]. Resident 53's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), heart failure (heart muscle is too weak to pump enough blood and oxygen to meet your body's needs), and hyperlipidemia (high cholesterol). During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53's cognitive skills for daily decision making were intact. The MDS indicated Resident 53 required supervision for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal hygiene and oral hygiene. During a review of Resident 53's H&P dated 6/27/25, the H&P indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's physician's order, dated 9/24/2025, the order indicated to administer dapagliflozin pro-metformin (used to treat diabetes, a disorder characterized by difficulty in blood sugar control and poor wound healing) extended release oral tablet of 10-1000 milligrams (mg, a unit of dose measurement) one tablet in the morning for diabetes. During a review of Resident 53's physician's order, dated 9/24/2025, the order indicated to administer pioglitazone (diabetes medication) oral tablet 30 mg, 1 tablet, by mouth one time a day for diabetes. During a review of Resident 53's physician's order, dated 11/18/2025, the order indicated to inject glargine insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) 18 units subcutaneously (delivers medication into the fatty layer of tissue just below the skin), in the morning, for diabetes. During a concurrent interview and record review on 6/3/2026 at 9:27 a.m., with LVN 4, LVN 4 reviewed Resident 53's electronic medical record was reviewed. LVN 4 stated that she was unable to locate a care plan addressing the resident's prescribed diabetic medications, including dapagliflozin-pro-metformin, glargine insulin, and pioglitazone. LVN 4 stated that these medications should be reflected in the resident's individualized care plan so that all nursing staff were aware of the resident's diagnosis, medication regimen, monitoring requirements, potential adverse reactions, and interventions. LVN 4 stated that the interdisciplinary care plan was intended to provide consistent guidance for staff and ensure continuity of care across all shifts. LVN 4 stated that the absence of care plan interventions for these medications could result in inconsistent care, missed monitoring for signs and symptoms of hypo- or hyperglycemia, and staff being unaware of appropriate interventions related to the resident's diabetic management.During a concurrent interview and record review on 6/3/2026 at 2:40 p.m., with the Director of Nursing (DON), the electronic medical record for Resident 53 was reviewed. The DON stated that physician orders were present for dapagliflozin-pro-metformin, glargine insulin, and pioglitazone but was unable to locate corresponding care plan interventions addressing the resident's diabetic medication regimen. The DON stated that the facility's expectation was that every resident's care plan was comprehensive, individualized, and updated to reflect current diagnoses, physician orders, medications, and interventions. The DON stated that medications used to manage diabetes should be included in the care plan to provide guidance for nursing staff regarding blood glucose monitoring, recognition and reporting of adverse effects, prevention of complications, and appropriate resident-specific interventions. The DON stated that the absence of these care plan interventions did not reflect the facility's standard of practice and could lead to inconsistent implementation of care and communication among interdisciplinary staff responsible for the resident's treatment and ongoing diabetic management (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including dementia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and heart failure. During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for ADls. During a review of Resident 40's H&P dated 7/1/2025, the H&P indicated Resident 40 had fluctuating capacity to understand and make decisions. During a review of Resident 40's physician order, dated 9/5/2025, the physician order indicated to administer Midodrine (used to treat symptomatic orthostatic hypotension [a sudden drop in blood pressure when standing up]) 10 milligrams (mg, a unit of dose measurement), one tablet by mouth three times a day for hypotension (low blood pressure). During a concurrent interview and record review on 6/2/2026 at 1:00 p.m., with LVN 3, Resident 40's medical records as reviewed. The records did not indicate a care plan was developed for Midodrine. LVN 3 stated there was no care plan developed for Resident 40's use of Midodrine. LVN 3 stated Resident 40 should have an individualized care plan for Midodrine with interventions developed to guide licensed nurses on providing education, monitoring for medication side effects, monitoring medication effectiveness, and implementing appropriate measures as needed. LVN 3 stated this failure had the potential to place Resident 40 at risk for not being monitored for side effects and effectiveness of Midodrine, and for not receiving individualized care and interventions related to the use of the medication. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes, b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During a review of the facility's P&P titled, Oxygen Administration, revised 2/2024, the P&P indicated, Review the resident's care plan to assess any special needs of the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure there was a physician order for oxygen use for one of one sampled resident (Resident 84) who was receiving oxygen.This failure had the potential to result in Resident 84 experiencing respiratory complications, including excessive oxygenation and carbon dioxide retention (build up the body's natural waste gas in the bloodstream.During a review of Resident 84's admission Record, the admission Record indicated, the facility admitted Resident 84 on 5/20/2022 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), pleural effusion (excess fluid in the space between your lungs and the inside of your chest wall), chronic pulmonary edema (buildup of excess fluid in the tiny air sacs of in the lungs), and asthma (lung condition where the airways swell, tighten, and fill with mucus).During a review of Resident 84's History and Physical (H&P), dated 5/15/2026, the H&P indicated Resident 84 can make needs known but cannot make medical decisions.During a review of Resident 84's Minimum Data Set (MDS - a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 84 had shortness of breath or trouble breathing when lying flat. The MDS indicated Resident 84 was receiving intermittent oxygen therapy on admission and while a resident.During an observation on 6/1/2026 at 1:10 p.m. in Resident 84's room, Resident 84 was lying in bed and receiving 4 liters (L - metric unit of measurement, used for measuring the volume of liquids or gases) of oxygen through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen).During an observation on 6/2/2026 at 10:50 a.m. in Resident 84's room, Resident 84 was lying in bed receiving 4 L of oxygen through a nasal cannula.During a concurrent interview and record review on 6/2/2026 at 11:03 a.m. with LVN 1, Resident 84's physician orders were reviewed. The resident's physician orders indicated no order for oxygen therapy. LVN 1 stated, oxygen was considered a medication and should not be administered to Resident 84 without an active physician order. LVN 1 stated, Resident 84 was at risk for excessive oxygenation, carbon dioxide retention, and suffocation without an active physician order for oxygen therapy.During a concurrent interview and record review on 6/2/2026 at 12:56 p.m. with the Director of Nursing (DON), Resident 84's physician order was reviewed. The DON stated, Resident 84 should have an active physician order for oxygen when receiving oxygen therapy. The DON stated, without a physician's order for oxygen therapy, Resident 84 was at risk for breathing complications, including over oxygenation and carbon dioxide retention.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised February 2024, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two staff-dependent sampled residents' (Resident 46 and Resident 12) fingernails were trimmed and maintained in a clean manner.This deficient practice had the potential to result in a negative impact on Resident 46 and Resident 12's quality of life and self-esteem, and had the potential to result in sustaining skin injury from scratching and developing an infection. Findings: 1. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was initially admitted to the facility on [DATE] and was re-admitted on [DATE]. Resident 46's diagnoses included bilateral osteoarthritis of knee (arthritis in both knees, causing pain and stiffness), dementia (a progressive state of decline in mental abilities), and dysphagia (difficult swallowing). During a review of Resident 46's Minimum Data Set (MDS – a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 46's cognitive skills for daily decision making (ability to think) was moderately impaired. The MDS indicated Resident 46 required maximal assistance (helper does more than half the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as eating, bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 6/2/2026 at 8:51 a.m., at Resident 46's bedside, Resident 46's fingernails were observed. Resident 46's fingernails were long and untrimmed with black debris underneath the nail bed. During a concurrent observation and interview on 6/3/2026 at 1:50 p.m., at Resident 46's bedside, with Certified Nursing Assistant (CNA) 3, Resident 46's fingernails were observed. Resident 46's fingernails were long and untrimmed. CNA 3 stated Resident 46's fingernails were sharp, long and required trimming. CNA 3 stated nail care was one of the responsibilities of the CNA which included trimming and cleaning the resident's fingernails when they become long and dirty. CNA 3 stated residents' nails should be checked daily to ensure the nails remained clean and neat. CNA 3 stated residents sometimes scratched their skin, and if they scratched hard enough, they could break the skin and create an open wound. CNA 3 stated if a resident had dirty fingernails and scratched themselves, this increased the risk of infection. During an interview with the Infection Preventionist Nurse (IPN) on 6/3/2026 at 2:00 p.m., the IPN stated nail care should be assessed daily. The IPN stated residents who required assistance with cleaning or trimming their nails should be assisted by the CNA's or licensed nurses. The IPN stated fingernails were a source of bacteria, and that dirty or untrimmed nails could contribute to the spread of infection, especially among residents who may not be able to maintain their own hygiene. The IPN stated routine nail care was an essential part of both personal hygiene and infection control. During an interview on 6/3/2026 at 2:35 p.m., with the ADON, the ADON stated fingernail care was a part of the resident's ADL routine. The ADON stated if a resident had long and dirty fingernails, CNAs were expected to clean and trim them. The DON stated dirty fingernails was not acceptable, as they increased the risk of infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 12's admission Record, the admission Record indicated, the facility admitted the resident on 8/27/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), polyarthritis (pain, swelling, and stiffness in multiple joints), and tinea unguium (fungal infection of the nails). During a review of Resident 12's History and Physical (H&P), dated 2/28/2026, the H&P indicated Resident 12 had the capacity to understand and make medical decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated, Resident 12 was dependent on staff for self-care, including activities such as grooming and bathing. During an observation on 6/1/2026 at 9:58 a.m. in Resident 12's room, Resident 12 was lying in bed. Resident 12 had thick, yellow, and overgrown fingernail on her right first digit, where the fingernail curled beneath the fingertip. Resident 12 had thick and yellow fingernail on her left fifth digit. During an interview on 6/3/2026 at 1:50 p.m. with CNA 1 in the presence of CNA 2, CNA 1 stated, Resident 12's fingernails needed to be trimmed. CNA 1 stated, the CNAs were responsible for providing fingernail care for the residents when the fingernails became too long. CNA 1 stated, if she was unable to provide fingernail care for a resident, she would notify the charge nurse. CNA 1 stated, she notified the charge nurse on 1/2026 but could not state who the charge nurse she reported to. During an interview on 6/3/2026 at 2:20 p.m. with the IPN, the IPN stated, if a CNA was unable to provide fingernail care for a resident due to overgrowth, the CNA will notify the charge nurse, the charge nurse will then notify the doctor, and then the wound care doctor would be consulted for further evaluation and management of the resident's fingernail care needs. The IP stated, a resident who did not receive appropriate fingernail care was at risk for developing ingrown fingernails, scratching and injuring themself, and developing infections from microorganisms that may accumulate under the fingernails. During an interview and record review on 6/4/2026 at 8:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated, the resident's progress notes indicated a podiatrist, dermatologist, or wound care doctor has not seen the resident regarding her right first digit and left fifth digit fingernails. During a concurrent interview and record review on 6/4/2026 at 10:27 a.m. with the Director of Nursing (DON), Resident 12's Progress Note – Acute Care, dated 12/29/2025, was reviewed. The DON stated, Resident 12 should have been provided care for her right first digit fingernail and left fifth digit fingernail. Resident 12's unclean fingernails may harbor bacteria, which could contribute to infection if the bacteria was introduced into the skin through scratching. During a review of Resident 12's Progress Note – Acute Care, dated 12/29/2025, the Progress Note – Acute Care indicated, Cleanse affected fingernails with normal saline, pat dry. Apply Ciclopirox 8% topical solution (nail lacquer) to affected fingernails once daily. Continue treatment for 30 days.Consider podiatry or dermatology referral if no improvement after treatment course. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, revised February 2018, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming. The P&P indicated nail care includes daily cleaning and regular trimming to prevent infections.

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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 observation, interview, and record review, the facility failed to ensure two of two sampled residents' (Resident 18 and Resident 21) room was free of accidents and hazards when Resident 18's headboard was observed broken and hanging away from the bed frame, and Resident 21's smoking assessment was not updated and smoking paraphernalia was not appropriately stored. These deficient practices placed Resident 18 and Resident 21 at risk for injury and an unsafe environment. Findings: 1. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 18's diagnoses included dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle weakness. During a review of Resident 18's History and Physical (H&P), dated 7/31/2025, the H&P indicated Resident 18 had fluctuating capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 18's cognitive skills for daily decision making (the ability to think and process information) was impaired. The MDS indicated Resident 18 requird maximal assistance (helper does more than half the effort) on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 6/03/2026 at 12:40 p.m., at Resident 18's bedside, Resident 18 was observed sitting on a wheelchair. The headboard was broken and hanging away from the bed frame. The right lower corner of the headboard was touching the floor. During a current observation and interview on 6/3/2026 at 12:42 p.m., with the Housekeeper (HK), in Resident 18's room, Resident 18's bed headboard was observed broken and not securely attached to the bed frame. The HK stated, broken headboards should be reported immediately to Director of Maintenance (DOM) for repair or replacement to ensure residents' safety. The HK further stated broken headboards, if left broken, could tip over or have exposed edges that may cause injury to residents. During an interview on 6/3/2026 at 1:33 p.m., with the DOM, the DOM stated, the resident beds must be kept in good condition. The DOM stated a damaged headboard was unsafe and should be reported for immediate repair. The DOM further stated failure to address the issue may place residents at risk for avoidable harm. During an interview on 6/3/2026 at 1:47 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated, the staff should report the broken headboard immediately for repair and failure to report the broken headboard could place the resident at risk of injury and unsafe living environment. During an interview on 6/4/2026 at 8:07 a.m., with the Director of Nursing (DON), the DON stated, a (continued on next page)

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Briarcrest Nursing Center	5648 East Gotham Street Bell Gardens, CA 90201

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	broken headboard causes hazards such as bruising, skin injuries, and negatively impacting residents' quality of life by creating an unsafe setting. During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, dated 8/2022, the P&P indicated the maintenance staff routinely inspects all beds to identify risks and problems, any broken or malfunction (not working properly) bed system are repaired or replaced using manufacturer specifications (the instructions from the company that made the bed or equipment). 2. During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE]. Resident 21's diagnoses included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and hyperlipidemia (an excess of lipids or fats in your blood). During a review of Resident 21's H&P dated 2/22/2026, the H&P indicated Resident 21 had fluctuating capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated resident had moderate cognitive impairment. The MDS indicated Resident 21 required staff supervision for toileting, dressing and partial assistance for personal hygiene. During a concurrent observation and interview on 6/1/2026 at 9:52 a.m. with Registered Nurse (RN) 2, in Resident 21's room, Resident 21 was observed lying in bed with a blanket covering his face. A lighter and cigarette were observed on his bedside table. RN 2 stated Resident 21 was an independent smoker and was allowed to have smoking materials in his room, but the smoking materials should be secured in a drawer. RN 2 stated failure to properly store the smoking materials could result in other residents accessing the materials which posed a safety and fire hazard. During a concurrent interview and record review on 6/3/2026 at 9:27 a.m. with RN 1, Resident 21's smoking assessment dated [DATE] and Change in Condition evaluation dated 5/2/2026 were reviewed. The smoking assessment indicated Resident 21 followed smoking guidelines per facility policy. The Change in Condition evaluation indicated Resident 21 was seen smoking in his room and was educated that he was putting other residents at risk by smoking inside. RN 1 stated per facility policy, the smoking assessment should be updated with any change of condition. RN 1 stated there were no smoking assessments completed after Resident 21 was found smoking in his room on 5/2/2026, and an updated assessment should have indicated Resident 21 did not follow smoking guidelines. RN 1 stated Resident 21 should not have been able to store his own smoking materials. RN 1 stated failure to update Resident 21's smoking assessment and ensure safe storage of smoking materials placed Resident 21 at risk for accidents and all residents, staff and visitors at risk for a fire hazard. During an interview on 6/4/2026 at 9:32 a.m. with the DON, the DON stated Resident 21's smoking assessment should have been updated and the resident should not have been able to keep his own smoking materials. The DON stated updated smoking assessments and secure storage of smoking materials were important to ensure the safety of all residents, visitors, and staff. During a review of the facility's P&P titled, Smoking Policy- Residents last revised October 2023, the P&P indicated, A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. The P&P indicated, Residents without (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the urine characteristics and document urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) care for one of one sampled residents (Resident 127), with an indwelling urinary catheter.These deficient practices had the potential to lead to delayed treatment and identification of urinary tract infections (UTI- an infection in the bladder/urinary tract) and improper urinary catheter management for Residents 127.Findings:During a review of Resident 127's admission Record, the admission Record indicated Resident 127 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 127's diagnoses included neuromuscular dysfunction of bladder (a bladder problem caused by damaged nerves that makes it hard to control when urinate), dependence on respiratory ventilator (a medical device to help support or replace breathing), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 127's Minimum Data Set (MDS- a resident assessment tool), dated 5/5/2026, the MDS indicated Resident 127's cognitive skills for daily decision making (process of thinking) was moderately impaired. The MDS indicated Resident 127 was dependent on staff with toileting, bathing, and lower body dressing. The MDS indicated Resident 127 had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 127's History and Physical (H&P), dated 2/10/2026, the H&P indicated Resident 127 had fluctuating capacity to understand and make decisions. During a review of Resident 127's care plan titled The resident has Foley (indwelling) catheter., dated 2/13/2026, the care plan indicated to monitor and document Resident 127's Foley catheter care every shift for urine color, sediments, cloudiness, odor, blood, and amount of output. During a concurrent interview and record review on 6/3/2026 at 10:51 a.m., with the Treatment Nurse (TN), Resident 127's Treatment Administration Record (TAR), dated 5/1/2026 through 6/1/2026, was reviewed. The TAR did not indicate Foley catheter care monitoring was performed each shift. The TN stated the lack of consistent monitoring and documentation increased Resident 127's risk of infection. During an interview on 6/3/2026 at 2:11 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Foley catheter care should be monitored and documented each shift by the TN. The ADON stated this placed Resident 127 at risk for infection, development of a catheter-associated UTI, and other preventable infection-related complications. During a review of the facility's policy and procedure (P&P) titled Catheter Care, Urinary, revised 8/2022, the P&P indicated to observe the resident for complications associated with urinary catheters. The P&P indicated the following information should be recorded in the resident's medical record:1. The date and time that catheter care was given.2. The name and title of the individual(s) giving the catheter care.3. All assessment data obtained when giving catheter care.4. Character of urine such as color, clarity, and odor.5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain.6. Any problems or complaints made by the resident related to the procedure.7. How the resident tolerated the procedure.8. If the resident refused the procedure, the reason(s) why and the intervention taken.9. The signature and title of the person recording the data.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that feeding assistance was provided to one of four sample residents (Resident 2) who required feeding assistance with meals.This deficit practice placed Resident 2 at risk for choking, aspiration (accidental inhalation of food, liquid, or stomach contents into the airway), inadequate nutritional and fluid intake, weight loss, dehydration, and a decline in overall health status.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 readmitted on [DATE]. Resident 2's diagnoses included dysphagia (difficulty swallowing), lack of coordination, dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure), and acute respiratory failure with hypoxia (a life-threatening medical emergency where the lungs cannot adequately oxygenate the blood).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's physician diet order, dated 5/11/2026, the order indicated regular, large portions diet, pureed (foods blended to a smooth, uniform, pudding-like consistency that requires no chewing) texture, mildly thick consistency. The order indicated to provide a feeder.During an observation on 6/1/2026 at 11:00 a.m., inside Resident 2's room, Resident 2 was observed scooping her pureed meal with her right index finger. No staff member was present at the bedside providing feeding assistance, cueing, or supervision.During a concurrent observation and interview on 6/3/2026 at 12:36 p.m., with Certified Nurse Assistant (CNA) 1, Resident 2 was observed sitting upright in bed. A lunch tray was positioned over the Resident 2's lap. Resident 2 was observed scooping the food with her fingers. No staff member was present at the bedside providing feeding assistance, cueing, or supervision. CNA 1 stated that Resident 2 was a feeder and required staff assistance during meals. CNA 1 stated staff were expected to assist residents identified as feeders to ensure adequate nutritional intake and to reduce the risk of choking, aspiration, and difficulty consuming meals. CNA 1 stated that Resident 2 should not have been left to eat independently and stated that staff should remain available to provide feeding assistance throughout the meal as needed. CNA 1 stated that no staff member was assisting Resident 2 at the time of the observation.During a concurrent interview and record review on 6/3/2026 at 2:46 p.m., with the Director of Nursing (DON), the DON reviewed Resident 2's clinical record, including Resident 2's physician order dated 5/11/2026. The DON stated that Resident 2 was identified as requiring feeding assistance during meals and that staff were expected to provide direct assistance, supervision, and encouragement to ensure the resident consumed meals safely and received adequate nutrition and hydration. The DON stated that residents requiring feeding assistance should never be left to eat independently without staff support, as this placed the residents at risk for inadequate nutritional intake, choking, aspiration, and other adverse outcomes. The DON stated that CNA's were responsible for following Resident 2's feeding orders and providing assistance for the duration of the meal or until the resident safely completed eating. The DON stated that Resident 2's observation of eating unsupervised was not consistent with the facility's expectations or standards of care. The DON stated that staff should have been present to assist Resident 2 to ensure safe meal consumption and Resident 2's nutritional needs were met.During a review of the facility's policies and Procedures (P&P) titled Assistance with Meals dated 3/2022, the P&P indicated Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents Requiring Full Assistance: Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's consultant pharmacist's Medication Regime Review (MRR- a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication, to the physician) recommendations for ammonia level (a blood test used to measure the amount of ammonia [a waste product] in the blood) laboratory test were completed for two of two sampled residents (Residents 14 and 40). This deficient practice resulted in Residents 14 and 40's recommended blood laboratory tests not being performed and had the potential to place the residents at risk for delayed identification and treatment of elevated ammonia levels and adverse drug reaction. Cross reference F580Findings: a. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), epilepsy (a neurological disorder characterized by recurrent, unprovoked seizure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool), dated 8/17/2025, the MDS indicated Resident 14's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 14 required moderate (helper does less than half the effort) assistance from staff for 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 14's History and Physical (H&P), dated 10/4/2025, the H&P indicated Resident 14 had the capacity to understand and make decisions. During a review of Resident 14's physician order, dated 3/19/2026, the physician order indicated to administer Depakote 500 milligrams (mg, a unit of dose measurement), one tablet by mouth two times a day for seizure. During a review of Resident 14's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/1/2026 to 6/3/2026. The MAR indicated Resident 14 received Depakote (used to treat epilepsy) 500 mg two times a day from 3/20/2026 to 6/3/2026. During a concurrent interview and record review on 6/3/2026 at 2:20 p.m., with the Director of Nursing (DON), Resident 14's Medication Regime Review (MRR) dated 5/1/2026 to 5/11/2026, was reviewed. The MRR indicated the facility's consultant pharmacist recommended an ammonia level laboratory test. The MRR did not indicate Resident 14's physician was notified of the pharmacist's recommendation. The DON stated there was no documentation that the physician reviewed the MRR or addressed the recommendation. The DON stated Resident 14 did not have an ammonia level ordered or drawn. The DON stated the pharmacist's recommendation was not communicated to Resident 14's physician. b. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and heart failure (heart muscle is too weak to pump enough blood and oxygen to meet your body's needs). During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily living was moderately impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for ADLs. During a review of Resident 40's H&P dated 7/1/2025, the H&P indicated Resident 40 had fluctuating capacity to understand and make decisions. During a review of Resident 40's physician's order, dated 10/9/2025, the physician's order indicated to administer Divalproex Sodium (an anticonvulsant [mood stabilizer] medication) 125 mg, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two capsules by mouth two times a day for mood swings and continuous yelling. During a concurrent interview and record review on 6/3/2026 at 2:45 p.m., with the DON, Resident 40's MRR dated 5/1/2026 to 5/11/2026, was reviewed. The MRR indicated the facility's consultant pharmacist recommended an ammonia level due to Resident 40 receiving Divalproex Sodium medication. The MRR did not indicate Resident 40's physician was notified of the pharmacist's recommendation. The DON stated there was no documentation Resident 40's physician reviewed the MRR or addressed the recommendation. The DON stated Resident 40 did not have an ammonia level ordered or drawn and the pharmacist's recommendation was not communicated to the physician. During an interview on 6/3/2026 at 3:06 p.m., with the DON, the DON stated ammonia levels were necessary for Residents 14 and 40. The DON stated the ammonia levels monitored abnormalities in the blood. The DON stated an elevated ammonia level could cause symptoms such as confusion, sleepiness, behavior changes, decreased alertness, or other serious complications if not monitored and addressed. The DON stated the facility failed to ensure the consultant pharmacist's drug regiment review recommendations were communicated to Resident 14 and 40's physicians. The DON stated this placed the residents at risk for delayed identification and treatment of elevated ammonia levels while receiving Depakote and Divalproex Sodium. During a review of the facility's policy and procedure (P&P) titled Medication Regiment Review, revised 4/2007, the P&P indicated the consultant pharmacist will provide the Director of Nursing with written, signed and a dated report listing any irregularities and recommendations. The P&P indicated the facility staff were required to manage drug regiments to optimize resident's functioning and prevent or reduce negative effects from medication therapy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) and Midodrine (medication used to treat hypotension [low blood pressure]) were administered within the ordered parameters (specific, measurable, and objective clinical criteria set by a healthcare provider that dictate when a medication should be given, withheld, or adjusted) for two of three sampled residents (Residents 8 and 40). This deficient practice placed Resident 8 at risk for hypoglycemia (low blood sugar) and related complications, and placed Resident 40 at risk for an unsafe increase in blood pressure, headache, dizziness, slow heart rate, and other adverse effects related to medication administration outside of ordered parameters. Findings: 1. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE]. Resident 8's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), glaucoma (slow and progressive eye damage leading to blindness), and chronic kidney disease (chronic kidneys damage that cannot filter blood properly). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 8's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 8 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 8's physician order, dated 2/9/2026, the order indicated to inject Insulin NPH (diabetes medication), 14 units (a unit of measurement) subcutaneously (below the skin), in the morning for DM. The order indicated to hold the medication if the blood sugar level was less than (<) 110 milligram/deciliter (mg- a unit of weight/ dl- a unit of volume). During a review of Resident 8's Blood Glucose Monitoring (BGM) record for the month of March 2026, the BGM record indicated that on 3/19/2026, Licensed Vocational Nurse (LVN 6) administered 14 units of insulin for a blood sugar level of 106 mg/dl. During a review of Resident 8's BGM record for the month of April 2026, the BGM record indicated that on 4/3/2026, LVN 6 administered 14 units of insulin for a blood sugar level of 83 mg/dl. The BGM record indicated that on 4/27/2026, LVN 6 administered 14 units of insulin for a blood sugar level of 84 mg/dl. During a concurrent interview and record review conducted on 6/3/2026 at 2:28 p.m., with the Director of Nursing (DON), Resident 8's BGM records for March and April 2026 were reviewed. The DON stated that according to the physician's order, the scheduled morning dose of 14 units of insulin was to be withheld when the resident's blood glucose level was below 110 mg/dL. The DON reviewed the documentation and stated that on 3/19/2026, 4/3/2026, and 4/27/2026, Resident 8's blood glucose levels were below the ordered parameter. The DON stated the scheduled 14-unit morning dose of insulin was administered instead of being held as ordered. The DON stated that the physician's order should have been followed and that the insulin should not have been given. The DON (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that nursing staff were responsible for reviewing the physician's orders and the resident's blood glucose results before administering insulin to ensure the medication was given safely and according to the prescribed parameters. The DON stated that administering insulin when blood glucose levels were below the ordered threshold placed the resident at risk for hypoglycemia, which could result in dizziness, confusion, weakness, loss of consciousness, seizures, falls, serious injury, or other adverse outcomes. The DON stated that following physician orders and established medication administration protocols was essential to protect residents' safety and prevent avoidable medication errors. During a phone interview on 6/4/2026 at 8:28 a.m., with LVN 6, LVN 6 stated Resident 8's insulin should have been held for sugar levels below 110 mg/dl. LVN 6 stated that on 3/19/2026, 4/3/2026, and 4/27/2026, the 14 units of insulin should not have been given in accordance with the physician's order. LVN 6 stated administering insulin outside of the ordered parameters could place Resident 8 at risk for hypoglycemia, including symptoms such as dizziness, confusion, weakness, loss of consciousness, seizures, or other serious adverse outcomes. LVN 6 stated that adherence to physician orders was an essential component of safe medication administration and helped prevent avoidable resident harm. 2. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and heart failure (heart muscle is too weak to pump enough blood and oxygen to meet your body's needs). During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for ADLs. During a review of Resident 40's History and Physical (H&P) dated 7/1/2025, the H&P indicated Resident 40 had fluctuating capacity to understand and make decisions. During a review of Resident 40's physician order, dated 9/5/2025, the physician order indicated to administer Midodrine 10 mg, one tablet by mouth three times a day for hypotension. The order indicated to hold if systolic blood pressure ([SBP]- the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was greater than 130 millimeters of mercury (mm Hg, unit of pressure measurement). During an interview on 6/2/2026 at 1:00 p.m., with LVN 3, LVN 3 stated prior to administering Midodrine, the licensed nurse was responsible for checking that Resident 40's blood pressure was within the ordered parameters. LVN 3 stated if Resident 40's blood pressure was greater than 130 mm Hg, the nurse would hold the Midodrine. LVN 3 stated whether Midodrine was administered or held, the licensed nurse was responsible for documenting accurately on the Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). During a concurrent interview and record review on 6/3/2026 at 1:19 p.m., with Registered Nurse (RN) 1, Resident 40's MAR, dated 4/1/2026 through 5/31/2026, was reviewed. The MAR indicated Resident 40 was administered Midodrine 10 mg for the following SBP readings on the following dates: (continued on next page)

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	056220	A. Building B. Wing	06/04/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 4/14/2026- SBP of 136 mm Hg. b. 5/10/2026- SBP of 133 mm Hg. c. 5/11/2026- SBP of 133 mm Hg. d. 5/31/2026- SBP of 136 mm Hg. RN 1 stated Midodrine should not have been administered when Resident 40's SBP was above 130 mm Hg. RN 1 stated Midodrine was a medication used to help increase blood pressure. RN 1 stated the licensed nurses were responsible for checking the resident's blood pressure before administering and holding Midodrine when the SBP was above the ordered parameters. RN 1 stated Midodrine was not administered in accordance with the physician's ordered parameters. RN 1 stated administering Midodrine when Resident 40's SBP was above 130 mm Hg placed the resident at risk for hypertension (high blood pressure), dizziness, blurred vision, slow heart rate, falls, and other adverse effects related to high blood pressure. RN 1 stated this resulted in Resident 40 receiving medication outside the ordered parameters. During a review of the facility's policy and procedure (P&P) titled Insulin Administration revision dated 9/2014, the P&P indicated To provide guidelines for the safe administration of insulin to residents with diabetes. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. Check blood glucose per physician order or facility protocol. Check the order for the amount of insulin. During a review of the facility's P&P titled Administering Medications, revised 4/2023, the P&P indicated the licensed nurse was to administer medications in accordance with prescriber orders, including any required parameters. During a review of the facility's P&P titled Charge Nurse-Job Description, undated, the P&P indicated the change nurse was responsible for preparing and administering medications as ordered by the physician.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 101) who was prescribed a fortified diet (diet enhanced to increase caloric content) was served a fortified lunch.This deficient practice had the potential to place Resident 101 at risk of decreased caloric intake and unmet nutritional needs.Findings:During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was admitted to the facility on [DATE]. Resident 101's diagnoses included hypertension (HTN- high blood pressure), dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities).During a review of Resident 101's History and Physical (H&P) dated 2/28/2026, the H&P indicated Resident 101 had fluctuating capacity to understand and make decisions.During a review of Resident 101's Minimum Data Set (MDS- a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 101 had severe cognitive (ability to think and understand) impairment. The MDS indicated Resident 101 was dependent on staff for toileting, bathing and required partial assistance with eating.During a review of Resident 101's physician orders dated 3/29/2026, the physician orders indicated to provide a fortified diet, minced and moist texture, moderately thick consistency.During an interview on 6/2/2026 at 12:10 p.m. with the Dietary Supervisor (DS), the DS stated residents with fortified diets would receive a fortified mushroom soup.During a concurrent observation and interview on 6/2/2026 at 12:35 p.m. with Registered Nurse (RN) 2, in the dining room, Resident 101's lunch ticket indicated Fortified high protein diet. Resident 101's tray was observed without the fortified mushroom soup. RN 1 stated kitchen staff should have ensured Resident 101 received a fortified lunch diet as her meal ticket indicated. RN 1 stated ensuring fortified diets were served was important because residents with fortified diets required extra calories and nutrients.During an interview on 6/2/2026 at 1:35 p.m. with Dietary Aide (DA) 1, DA 1 stated she should have communicated Resident 101's fortified diet order during tray line to ensure the correct lunch tray was prepared. DA 1 stated resident diet orders should be followed to ensure residents receive the nutrients they need.During an interview on 6/2/2026 at 2:47 p.m. with the DS, the DS stated during tray line the DA was expected to communicate each residents diet order to the cook to ensure the correct meal tray was prepared. The DS stated failure to ensure residents received the correct meal tray placed residents at risk of unmet nutritional needs.During a review of the facility's policy and procedure (P&P) titled, Fortified High Calorie Diet, last revised 3/2026, the P&P indicated, The fortified diet is used when additional amounts of protein and/or calories are needed. Residents with inadequate intake, increased calorie or protein needs or who are at risk for malnutrition can benefit from this diet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) protocol for one of four residents (Residents 107) by not wearing the required personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing care to Resident 107.This deficient practice placed Resident 107 and other residents at increased risk for infections.Findings:During a review of Resident 107's admission Record, the admission Record indicated Resident 107 was admitted to the facility on [DATE]. Resident 107's diagnoses included dementia (a progressive state of decline in mental abilities), hyperlipidemia (high cholesterol), dysphagia (difficulty swallowing), urinary tract infection (UTI, an infection in the bladder/urinary tract) and metabolic encephalopathy (electrolyte imbalance that disrupts normal brain function).During a review of Resident 107's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 107's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 107 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 107's physician order, dated 5/16/2026, the order indicated enhanced barrier precautions due to urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) and unhealed wounds.During an observation on 6/1/2026 at 10:05 a.m., inside Resident 107's room, Certified Nurse Assistant (CNA) 4 was observed repositioning Resident 107. CNA 4 was not wearing personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments).During an interview on 6/1/2025 at 10:15 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated that she forgot to don (put on) a gown before repositioning Resident 107, who was on Enhanced Barrier Precautions (EBP). CNA 4 stated that the required PPE for providing direct care to a resident on EBP included wearing both gloves and a gown prior to resident contact. CNA 4 stated that the gown was intended to prevent the transfer of microorganisms to staff clothing and reduce the risk of cross-contamination between residents and the environment. CNA 4 stated that she realized the omission after providing care and recognized that failing to wear the required gown was not consistent with facility infection prevention practices. CNA 4 stated that staff were expected to follow EBP signage and don the appropriate PPE every time direct resident care was provided to minimize the risk of transmission of multidrug-resistant organisms and protect resident safety.During a concurrent interview and record review on 6/2/2025 at 9:45 a.m., with the Director of Nursing (DON), the DON reviewed Resident 107's physician EBP orders dated 5/16/2026. The DON stated the EBP order was currently active and staff should follow the EBP precautions. The DON stated that staff providing high-contact resident care activities were required to don the appropriate PPE, including gloves and a gown, prior to entering the resident care area and before initiating care. The DON stated that repositioning a resident was considered a high-contact care activity requiring gown and glove use. The DON stated that adherence to EBP protocols was essential to prevent the transmission of MDROs and other infectious pathogens between residents, staff, and the environment. The DON stated that failing to wear the required gown during resident care was a breach of the facility's infection prevention and control practices and placed residents at risk for cross-contamination and healthcare-associated infections. The DON stated that staff were expected to follow posted precaution signage, perform hand hygiene, and utilize the required PPE consistently during every resident care encounter. The DON stated that providing care without the required gown would not be in accordance with the facility's policy or accepted standards of infection prevention practice.During a review of the facility's policies and procedures (P&P) titled Policies and Practices- Infection Control the P&P indicated This facility's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.During a review of the facilities P&P titled Enhanced Barrier Precautions dated 8/2022, the P&P indicated Enhanced barrier precautions (EBP) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room. Personal protective equipment is changed before caring for another resident.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the resident with an appropriate call light system that accommodated the resident's physical limitations for one of six sampled residents (Resident 95). This deficient practice resulted in Resident 95 being unable to independently summon staff assistance and placed the resident at risk for delayed response to care needs, delayed assistance, unmet needs, and potential injury due to inability to effectively communicate the need for assistance. Findings: During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 95 diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and dementia (a progressive state of decline in mental abilities). During a review of Resident 95's History and Physical (H&P), dated 10/31/2025, the H&P indicated Resident 95 did not have the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS- a resident assessment tool), dated 5/2026, the MDS indicated Resident 95's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 95 was dependent (helper does all the effort) on staff for 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 95's care plan titled ADL care deficit, dated 11/3/2025, the care plan indicated the resident will use the call light to call for assistance. During an observation on 6/1/2026 at 10:18 a.m., at Resident 95's bedside, Resident 95 was observed lying in bed with mittens (a type of hand covering that encloses your fingers together) applied to both hands. Resident 95's call light was placed across the resident's chest. Resident 95 was unable to independently grasp or activate the call light due to the mittens. During a concurrent observation and interview on 6/1/2026 at 10:56 a.m., with Respiratory Therapist (RT- a specialized healthcare professional who diagnoses, treats and manages patients who have breathing disorders) 1, at Resident 95's bedside, Resident 95 was observed lying in bed with mittens applied to both hands. The call light was positioned across the resident's chest. RT 1 stated Resident 95 would not be able to grasp or activate the call light while wearing bilateral mittens. RT 1 stated Resident 95 should have been provided with an appropriate alternative call system, such as a call pad, touch pad, or other adaptive device that the resident could activate despite having mittens applied to both hands. RT 1 stated Resident 95 must have an accessible means of summoning staff assistance at all times. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, undated, the P&P indicated the facility will ensure residents have access to the call light and are able to use it to request assistance when needed.