STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	**5648 EAST GOTHAM STREET , BELL GARDENS, California, 90201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two complaints and one facility-reported incident. Complaint numbers: 2804182 and 2962733. Facility-reported incident number: 2805407. The inspection was limited to the specific complaint and facility-reported incident investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued for complaint number 2804182. Three deficiencies were issued for complaint number 2805407 and facility-reported incident number 2962733. See Tag F580, Tag F628, and Tag F842.	F0000		04/17/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F0580	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F0580 Notify of Changes (Injury/Decline/Room, etc.) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 2 was immediately reassessed on 03/26/2026 by the Director of Nursing (DON) and licensed nurse. A comprehensive head-to-toe assessment was completed and documented in the medical record. The attending physician (PCP) were notified on 03/26/2026 of the allegation, identified bruise, and current condition. Physician orders were	04/17/2026

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 reverse for further 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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F0580 SS = D	Continued from page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, “Change in a Resident’s Condition or Status,” which indicated the nurse would notify the resident’s attending physician (PCP) for changes in condition for one of three sampled residents (Resident 2) when: Registered Nurse (RN) 1 identified a discoloration/bruise to Resident 2’s left hip area on 3/14/2026. Resident 2 alleged that on 3/14/2026, she was hit by a Certified Nurse Assistant (CNA). This failure had the potential to result in delayed	F0580	Continued from page 1 reviewed and implemented as indicated. The resident representative was notified on 03/26/2026. The interdisciplinary team (IDT) reviewed the incident to ensure psychosocial needs were addressed, including monitoring for behavioral changes related to the allegation. The facility corrected the documentation deficiency by ensuring the skin assessment findings were entered into the electronic medical record (EMR) and cross-referenced to the abuse investigation. Staff involved (RN-1) received immediate re-education by the Director of Nursing (DON) on 03/26/2026 regarding timely physician notification, documentation standards, and escalation protocol when the PCP is unavailable. No adverse outcome to the resident was identified. How the facility identifies other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On 03/28/2026, the Director of Nursing (DON) and/or designee conducted a 12-day look-back audit covering the period of 03/14/2026 through 03/26/2026 for residents who experienced a change of condition, incident, injury, or allegation of abuse. The audit included a review of Change of Condition (COC) documentation, incident/accident reports, and nursing progress notes to verify timely physician notification, completion of head-to-to-toe assessments, and accurate documentation in the electronic medical record (EMR). No other residents were identified and affected by the deficiency. Licensed staff involved received targeted re-education on notification requirements and escalation protocols by the Director of Staff Developer (DSD). What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. Briarcrest Nursing Center reinforced notification of changes to ensure compliance with physician notification and documentation requirements. A standardized escalation protocol was enforced requiring nursing staff to notify the Medical Director or physician on-call if the attending physician is not reached within one hour, with all attempts documented in the EMR and requiring completion of	04/17/2026

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F0580 SS = D	Continued from page 2 medical care for Resident 2 and had the potential to negatively affect the resident's psychological and physical well-being. Cross Reference F842 Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on 8/12/2019 and readmitted on 1/20/2025. The Admission Record indicated Resident 2's diagnoses included fracture (broken bone) of right femur (thighbone), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and anxiety disorder (mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/17/2026, the MDS indicated Resident 2 had severe cognitive impairments (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, showering/bathing self and bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 2's Change of Condition (COC), dated 3/14/2026, the COC indicated Resident 2 reported an allegation of abuse and the PCP was notified on 3/14/2026 at 4:24 p.m. The COC did not indicate a full body (head-to-toe) assessment was done after the facility was made aware of the allegation. The COC did not Resident 2 had a discoloration/bruise or that the PCP was notified about the bruise. During interview on 3/25/2026 at 3:45 p.m. and 3/26/2026 at 3:29 p.m., with RN 1, RN 1 stated he performed a full body assessment on Resident 2 after the resident alleged that during a shower on 3/14/2026, a CNA hit her on the head. RN 1 stated he found a finger-length bluish discoloration to Resident 2's hip on 3/14/2026. RN 1 stated the skin assessment was not placed in Resident 2's medical records and was recorded on a separate paper skin assessment form as part of the abuse investigation file. RN 1 stated he could not reach Resident 2's PCP regarding the resident's allegation of abuse and skin discoloration identified on 3/14/2026. RN 1 stated he should have informed the Medical Director	F0580	Continued from page 2 a head-to-toe assessment, injury documentation, and physician notification details prior to finalizing the entry. The facility reinforced its Abuse and Neglect Clinical Protocol to require that all assessment findings be documented in the EMR. Licensed nursing staff were provided mandatory re-education by Director of Staff and Development (DSD) on 03/27/2026 regarding facility policies, and escalation requirements. The DON and/or designee conducts a 24-hour review of all incidents and COC reports at the clinical start-up and stand down to ensure compliance and immediate correction of any deficiencies. How the facility plans to monitor its performance to make sure that solutions are sustained. To ensure sustained compliance, the facility incorporated privacy and confidentiality monitoring into its Quality Assurance and Performance Improvement (QAPI) program. The Medical records supervisor initiated weekly audits for four weeks beginning 03/26/2026, reviewing a change of condition or incident to ensure timely physician notification, proper escalation, and complete documentation. This is followed by monthly audits for three months. Audit findings are reported to the QAPI Committee monthly with corrective actions implemented as needed. If no negative trends are identified after three consecutive months, the monitoring will be discontinued and removed from active QAPI tracking. If trends are identified, the facility will revise and continue the monitoring plan. Dates when corrective action will be completed. 4/17/2026	04/17/2026

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F0580 SS = D	Continued from page 3 when attempts to notify the PCP failed, to ensure Resident 2's skin did not worsen and because any changes and allegations of abuse should have been reported to the PCP. During a concurrent interview and record review on 3/26/2026 at 4:40 p.m., with the Director of Nursing (DON), Resident 2's COC and skin assessment, dated 3/14/2026 were reviewed. The DON stated a head-to-toe skin assessment should be completed for all allegations of abuse, and the PCP should be notified if there were any skin discolorations identified. The DON stated staff should contact the Medical Director if they were unable to get a hold of the PCP. During a review of facility's P&P titled, "Change in a Resident's Condition or Status," undated, the P&P indicated, "The nurse will notify the resident's attending physician or physician on call when there has been a(n): accident or incident involving the resident." During a review of facility's P&P titled, "Abuse and Neglect – Clinical Protocol," dated 2018, the P&P indicated, "The nurse will assess the individual and document related findings," and indicated, "Assessment data will include injury assessment." The P&P also indicated, "The nurse will report findings to the physician."	F0580		04/17/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F0628	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F0628 Discharge Process How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 3 was immediately reviewed on 03/27/2026 following identification of the deficient practice. The facility verified that the resident was readmitted on 03/25/2026 without loss of bed or services. On 03/25/2026, the party responsible was contacted by the Director of Nursing (DON) and provided	04/17/2026

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F0628 SS = D	Continued from page 4 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required	F0628	Continued from page 4 re-education regarding the facility's bed-hold policy, including the 7-day bed-hold provision. A written Bed-Hold Notice was issued retroactively and explained to the party responsible, with documentation placed in the medical record. The interdisciplinary team reviewed the discharge and transfer documentation to ensure all required elements were completed. No adverse outcome occurred. How the facility identifies other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. A 12-day look-back audit was conducted by Medical Records Supervisor from 03/14/2026 through 03/26/2026 for residents transferred to the hospital or on therapeutic leave. The audit focused on compliance with written Bed-Hold Notice requirements at the time of transfer. A total of applicable transfer records was reviewed by the DON and Medical Records Supervisor. No additional residents were identified as missing, written Bed-Hold Notices at the time of transfer. All licensed nurses, unit managers, and admissions staff were re-educated on 03/27/2026 by the Development of Staff Development (DSD) on requirements for discharge documentation and bed-hold notification. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The facility will reinforce the systemic corrective actions on discharge process to ensure compliance with the requirements for discharge and bed-hold notification. A standardized Bed-Hold Notice process was incorporated into the transfer workflow, requiring completion of a written notice at the time of transfer or within 24 hours for emergency transfers. The Electronic Medical Record (EMR) was re-enforced to include a required field for Bed-Hold Notice documentation. Licensed nurses, admissions staff, and business office personnel were re-educated on 03/27/2026, by DSD to ensure understanding of regulatory requirements and facility expectations. How the facility plans to monitor its performance to	04/17/2026

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F0628 SS = D	Continued from page 5 by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F0628	Continued from page 5 make sure that solutions are sustained. To ensure sustained compliance, the facility incorporated privacy and confidentiality monitoring into its Quality Assurance and Performance Improvement (QAPI) program. The facility will monitor compliance through a structured audit process integrated into the Quality Assurance and Performance Improvement (QAPI) program. Weekly audits of randomly selected residents who experienced hospital transfers will be conducted for four consecutive weeks by Medical Records Supervisor from 03/28/2026 through 04/25/2026, followed by monthly audits for three months from May through July 2026. Audits will evaluate the presence, timeliness, and completeness of written Bed-Hold Notices, including documentation in the EMR and notification of the responsible party. Audit results will be reviewed by the Director of Nursing and/or designee and reported to the QAPI Committee monthly. Any identified non-compliance will result in immediate corrective action, including documentation correction, staff re-education, and progressive discipline if indicated. After three months, the QAPI Committee will evaluate audit findings for trends; if no trends are identified, the monitoring process will be discontinued, and if trends persist, corrective actions and monitoring will be extended to ensure sustained compliance. Dates when corrective action will be completed. 4/17/2026	04/17/2026

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F0628 SS = D	Continued from page 6 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F0628		04/17/2026

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F0628 SS = D	Continued from page 7 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide a Bed-Hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital [GACH] in anticipation of their return to the facility) written notification as indicated in its policy and procedure (P&P) titled, "Bed-Holds and Returns" to one of three residents (Resident 3), who was transferred to the GACH on 3/10/2026. This failure had the potential to violate Resident 3's right to a bed-hold and result in the resident's inability to return to his home at the facility. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on 12/18/2024 and was readmitted on 3/25/2026. The Admission Record indicated Resident 3's diagnoses included respiratory failure (a serious condition that makes it difficult to breath on your own) with hypoxia (low levels of oxygen in the body's tissues). During a review of Resident 3's History and Physical (H&P), dated 2/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS], a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 3 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, shower/bathe self and bed mobility (ability to roll from lying on back to left and right side, and return to lying on back on the bed). During a review of Resident 3's Discharge Summary, dated 3/10/2026, the Discharge Summary indicated Resident 3 was transferred to the GACH for a	F0628		04/17/2026

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F0628 SS = D	Continued from page 8 Gastrostomy Tube ([G-tube], a small tube placed through the belly into the stomach to provide food, fluids, and medicine directly to someone who cannot eat enough by mouth) replacement. During a review of Resident 3's, "Bed-hold Informed Consent/Notification Form (Bed-hold notice)," dated 2/21/2026, the form did not indicate that a Notice of Bed-hold was provided to Resident 3's responsible party (RP) after Resident 3 was transferred to the GACH on 3/10/2026. During an interview on 3/26/2026 at 2:47 p.m., with the Business Office Manager (BOM), the BOM stated that the nursing department was responsible for providing the Bed-hold Notice to the residents or RP. During a concurrent interview and record review on 3/26/2026 at 4:18 p.m., with the Director of Nursing (DON), Resident 3's Bed-hold Notice dated 2/21/2026, and facility's undated P&P titled, "Bed-Holds and Returns," were reviewed. The DON stated residents' beds should be held for 7 days when they are transferred to the GACH and staff would verbally inform the RPs regarding the bed-hold at the time of transfer. The DON stated she was not aware that any written notices should be provided to RPs. The DON stated according to the facility P&P, a written second notice should have been provided to Resident 3's RP at the time of transfer on 3/10/2026 and the facility did not follow this P&P. The DON stated that by not providing the bed-hold notice, Resident 3s RP might not be aware Resident 3 was able to return after hospitalization. During a review of facility's undated P&P titled, "Bed-Holds and Returns," the P&P indicated, "All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: Notice 1: well in advance of any transfer (e.g., in the admission packet); and Notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours)."	F0628		04/17/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5)	F0842	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0842 SS = D	Continued from page 9 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842	Continued from page 9 correction does not constitute admission or agreement by the provider of the truth or facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F0842 Resident Records - Identifiable Information How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 2's medical record was immediately corrected on 03/27/2026 to reflect a complete and accurate clinical picture. A late entry was entered by the Licensed Nurse documenting the full body assessment completed on 03/14/2026, including the identified bruise/discoloration to the left hip. The Change in Condition (COC) documentation was corrected to remove the inaccurate "PCP recommendation," and a clarification note was entered indicating that the physician was not reached at the time of the incident. The attending physician was notified on 03/26/2026, and appropriate clinical follow-up was completed. Staff involved (RN 1) received immediate re-education by the Director of Nursing on 3/26/2026 regarding accurate, complete, and non-speculative documentation per facility policy "Charting and Documentation". No adverse outcome to the resident was identified. How the facility identifies other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. A 12-day look-back audit was conducted by Medical Records Supervisor from 03/14/2026 through 03/26/2026 for residents with documented Change in Condition (COC), skin assessments, or incident reports. The audit focused on completeness of head-to-to-toe assessments, accuracy of documentation, and validation of physician communication. No additional residents were found to have inaccurate physician recommendations documented without verification. Licensed nurses were re-educated on requirements by the Director of Staff Developer (DSD) on 3/27/2026 emphasizing that all clinical findings must be documented in the medical record.	04/17/2026

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F0842 SS = D	Continued from page 10 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate clinical medical records, for one of three sampled residents (Resident 2) by failing to: Ensure Registered Nurse (RN) 1 documented Resident 2’s full body (head-to-toe) assessment and skin discoloration/bruise identified on 3/14/2026 in the resident's medical records. Ensure RN 1 did not document a “recommendation of PCP (Primary Care Physician)” in Resident 2's Change in Condition (COC) form without speaking with the PCP. This deficient practice had the potential to result in miscommunication between staff and a delay in the provision of care or interventions for Resident 2. Cross Reference F580 Findings:	F0842	Continued from page 10 What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The facility reinforced the standardized EMR documentation review for Change in Condition (COC) events requiring completion of a full body assessment, inclusion of all skin findings, and verification of physician communication prior to documenting any recommendations. The abuse investigation workflow was reenforced to ensure that clinical findings are integrated into the medical record to support continuity of care and regulatory compliance. Licensed nurses were re-educated by the DSD ON 03/27/2026 on documentation standards, including accuracy, completeness, and prohibition of speculative entries, as well as confidentiality requirements. These system changes were implemented to ensure medical records remain complete, accurate, and readily accessible, and to prevent recurrence of the deficient practice. How the facility plans to monitor its performance to make sure that solutions are sustained. To ensure sustained compliance, the facility incorporated privacy and confidentiality monitoring into its Quality Assurance and Performance Improvement (QAPI) program. The facility will reinforce the structured monitoring system to ensure sustained compliance. A weekly audit by the Medical Records Supervisor of randomly selected residents with Change in Condition documentation will be conducted for four consecutive weeks focusing on completeness, accuracy, and verified physician communication. Following this period, audits will be conducted monthly for three months. Audit results will be reviewed by the Director of Nursing and reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified discrepancies will result in immediate corrective action, including re-education and documentation correction. If no trends or repeat deficiencies are identified after three months, the issue will be considered resolved and removed from active QAPI monitoring. If trends are identified, the audit frequency will be increased and additional interventions implemented. The facility will evaluate the effectiveness of corrective actions through ongoing compliance rates.	04/17/2026

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F0842 SS = D	Continued from page 11 During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on 8/12/2019 and readmitted on 1/20/2025. The Admission Record indicated Resident 2's diagnoses included fracture (broken bone) of right femur (thighbone), dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and anxiety disorder (mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life). During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/17/2026, the MDS indicated Resident 2 had severe cognitive impairments (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene, showering/bathing self and bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 2's Change of Condition (COC), dated 3/14/2026, the COC indicated Resident 2 reported an allegation of abuse. The COC indicated Resident 2's PCP was notified on 3/14/2026 at 4:24 p.m. The COC indicated a recommendation of PCP included to "Monitor for pain and episodes of sadness/depression post 72 hours." The COC did not indicate a full body assessment was completed. The COC did not indicate Resident 2 had any discoloration/bruise. During an interview on 3/25/2026 at 3:45 p.m., with RN 1, RN 1 stated he performed a full body assessment on Resident 2 after the resident alleged that during a shower on 3/14/2026, a Certified Nurse Assistant (CNA) hit her on the head. RN 1 stated he found a finger length bluish discoloration to Resident 2's hip on 3/14/2026. RN 1 stated the skin assessment was not placed in Resident 2's medical records and was recorded on a separate paper skin assessment form as part of the abuse investigation file. During a review of Resident 2's skin assessment (submitted for the abuse investigation file), dated 3/14/2026, the skin assessment indicated Resident 2 was had a "bruise" to the left hip area. During a subsequent interview on 3/26/2026 at 3:29 p.m., with RN 1, RN 1 stated he could not reach Resident 2's PCP regarding the resident's allegation	F0842	Continued from page 11 Dates when corrective action will be completed. 4/17/2026	04/17/2026

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F0842 SS = D	Continued from page 12 of abuse on 3/14/2026. RN 1 stated Resident 2's COC was incorrect and the recommendation to "Monitor for pain and episodes of sadness/depression," should not have been documented. During a concurrent interview and record review on 3/26/2026 at 4:40 p.m., with the Director of Nursing (DON), Resident 2's COC and skin assessment, dated 3/14/2026 were reviewed. The DON stated if staff did not get a hold of the PCP, the PCP recommendation on the COC should have been left blank and attempts to reach the PCP should have been documented in the progress notes. The DON stated that Resident 2's COC also did not indicate that a bruise was found during the nurse's skin assessment on 3/14/2026. During a subsequent interview on 3/31/2026 at 3:10 p.m., with the DON, the DON stated a COC should include pertinent information including changes found during a full body assessment and should have been part of the resident's medical records so staff could notify the PCP and to obtain any new orders needed to treat changes to the resident's condition. During a review of facility's P&P titled, "Charting and Documentation," dated 7/2017, the P&P indicated "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." The P&P also indicated, "Documentation of procedures and treatments will include care-specific details, including the assessment data and/or any unusual findings obtained during the procedure/treatment and notification of family, physician or other staff, if indicated."	F0842		04/17/2026