DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during Recertification survey, and a Complaint investigation. Complaint No: CA00662293 Representing the department of Public Health: Health Facilities Evaluator, Nurse: 36926, RN, HFEN Health Facilities Evaluator, Nurse: 40168, RN, HFEN Health Facilities Evaluator, Nurse: 39028, RN, HFEN Health Facilities Evaluator, Nurse: 36385, RN, HFEN Health Facilities Evaluator, 28851, Pharmacy Consultant Survey Census: 127 Sample size: 25 Highest Severity and Scope: E No deficiencies were issued for Complaint No: CA00662293	F 000	**Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than 12/12/19** **Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907.** RP (Initials)	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess and	F 641	**F641 – It is the policy of this facility that all resident assessments must accurately reflect the resident's status.** **CORRECTIVE ACTION** On 11/13/19, the Director of Nursing (DON), clinical nurse consultant and Minimum Data Set Nurse (MDSN-1) reviewed Resident-38's range of motion (ROM) assessment and revised to show Resident-38's accurate ROM movement range, limitations and proper plan of care to address the assessment. On 12/13/19, MDSN-1 was given a 1:1 counseling by the MDS nurse consultant regarding ROM assessment and accurate coding of all MDS assessments to ensure residents	12/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RP — RAYMOND PELLICER — ADMINISTRATOR — 12/12/19

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.

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 641	Continued From page 1 document one of 25 sampled resident (38) accurate description of the range of motion ([ROM] the measurement of the amount of movement around a specific joint or body part) limitations. This deficient practice resulted in the Resident 38's Minimum Data Set ([MDS] a standardized comprehensive assessment and care screening tool) ROM limitations coded incorrectly, which placed the resident at risk for not receiving appropriate care, and interventions. Findings: During an observation on 11/13/19 at 1:06 p.m., Resident 38 was eating lunch while using the left hand. During a concurrent interview with Certified Nursing Assistant (CNA 2), who was in the room with the resident, stated the resident was receiving Restorative Nursing Assistance ([RNA] a program which assists residents to gain improved quality of life by increasing their level of strength and mobility). CNA 2 stated Resident 38 did not have limitations in ROM on the left side, but did have some limitations on the right lower side, with severe limitation on the right upper side. A review of Resident 38's admission record indicated the resident was admitted to the facility on 5/24/19 and re-admitted on 6/14/19 with diagnoses including of non traumatic intracranial hemorrhage (bleeding in the brain), hemiplegia (weakness and lack of control on one side of the body), and hemiparesis (paralysis of one side of the body).	F 641	receive appropriate care and interventions. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents with possibility of joint ROM decline could have been affected by this deficiency. The DON, physical therapy person and MDS staff reassessed all other residents on 11/13/19, focusing on ROM impairment for documentation and coding accuracy. No other residents were found similarly affected by this deficiency. **SYSTEMIC CHANGES** The medical records staff will complete random weekly audits of residents' assessments with focus on ROM impairments. Audit reports will be provided to the DON for accuracy review. During ROM exercises, the restorative nurse assistant (RNAs) will report decreased ROM impairment to the charge nurse for possible clarification with the physician, if needed. This policy will be in place permanently with quarterly review to monitor effectiveness. New admissions physical therapy staff will assess the resident with ROM impairment. Assessments will continue quarterly for Interdisciplinary Team (IDT) care plan meetings and after any change-of-condition, as necessary. **MONITORING EFFECTIVENESS** The MDS nurse consultant will conduct quarterly in-services to MDS staff discussing accurate assessment of residents with any ROM impairment reminding staff to contact the physician, if clarification is needed. This policy will be remaining in effect for the year. Resident care plans will be reviewed at the quarterly IDT meeting to ensure a	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 641	Continued From page 2 A review of the physical therapy order dated 8/21/19 indicated Resident 38 was to have passive range of motion (a therapist or equipment moves the joint through the range of motion with no effort from the resident) on every shift, to all the joints of the right side. During a record review with the Minimum Data Set Nurse (MDSN 1) on 11/13/19 at 1:57 p.m., Resident 38's comprehensive MDS assessment dated 5/31/19 indicated there was no ROM impairment on both upper extremities (shoulder, elbow, wrist, hand) and or lower extremities (hip, knee, ankle, foot). However, a review of Resident 38's MDS assessment dated 8/30/19 indicated the resident had an impairment on one side of the upper extremities and one side of the lower extremities. During a concurrent interview with Minimum Data Set Nurse (MDSN 1), the nurse stated the comprehensive assessment was done by a part-time MDS nurse. MDSN 1 stated Resident 38 had a diagnosis of hemiplegia and "really had impairment upon admission" to the facility. A review of an undated facility's policy and procedures titled "Resident Assessment Instrument" indicated the purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. The policy indicated the information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.	F 641	comprehensive care plan is reflective of the resident's needs and interests. The clinical nurse consultant and MDS nurse consultant will conduct random resident chart audits on a quarterly basis to ensure compliance with facility policies and regulations. Audit results will be reported to the DON and Administrator for review. Findings will be addressed by the DON and discussed in the monthly and quarterly Quality Assurance (QA) committee meeting as part of survey review for the next three months.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 3	F 656		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656	**F656 – It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.** **CORRECTIVE ACTION** A: On 11/14/19, Resident-118's care plan was reviewed and updated by the DON and MDS staff, with clarification made with the primary physician regarding non-compliance and refusal of care. On 12/11/19, an in-service by the clinical nurse consultant was given to Interdisciplinary Team (IDT) members, such as the Director of Rehab, Activity Supervisor, Dietary supervisor, Social services designee and MDS regarding resident behavior concerns with emphasis on proper documentation to ensure an accurate care plan is created and implemented. B: On 11/14/19, Resident-79's care plan was reviewed and updated by the DON with clarification made with the primary physician addressing goals to decrease striking out, decrease antipsychotic medication and clarifying supervision of the resident while in the Activity room. The licensed nurses were in-serviced from 12/03/19 to 12/06/19 by the DON regarding the development and implementation of facility residents' plan of care. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** A: On 11/14/19, the DON and RN supervisor reviewed other residents with noted behavior concerns, such as non-compliance and refusal of care. No other residents were found similarly affected by this deficiency.	12/11/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 4 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a care plan for two of 25 sampled residents (118, 79). Resident 118 had episodes of non-compliance and refusing care, however, the facility did not create a care plan to address the non-compliance and refusal of care. Resident 79's care plan did not include goals to decrease episodes of striking out and to decrease the use of the antipsychotic (primarily used to manage mental disorders such as psychosis [including delusions, hallucinations, paranoia or disordered thought]) medication, and was not revised after a fall to include how to supervise the resident in the activity room while conducting activities. This deficient practice had the potential to prevent facility staff from meeting the needs of Residents 118, and 79, and not allow the residents to attain or maintain his highest practicable physical, mental and psychosocial well-being. Findings: a. A review of Resident 118's admission form indicated the resident was originally admitted to	F 656	B: On 11/14/19, the DON and RN supervisor reviewed other residents with similar behavior and medication goals as Resident-79. No other residents were found similarly affected by this deficiency. **SYSTEMIC CHANGES** A.) All residents with documented non-compliance and/or continual refusal of care will be immediately re-assessed by the IDT team to ensure proper interventions and plan of care is in place with monthly review by the DON. The staff members will be responsible to implement the plan of care that was developed to address each resident's identified needs, preferences and problems/concerns. B1.) antipsychotic medication The DON or his designee will audit the clinical records of residents who had a change of condition to ensure that a plan of care had been developed to address each resident's individual needs and preferences and the identified problems/concerns. B2.) fall supervision The charge nurses during their shift will be responsible to ensure that each resident's plan of care was implemented as planned. The DSD or her designee will conduct observations of residents assessed as risk for falls, to ensure that the plans of care were implemented as planned and documented accurately. **MONITORING EFFECTIVENESS** The DON or his designee will monitor through observations and clinical record reviews of three residents monthly to ensure that a plan of care	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 5 the facility on 4/2/17 and re-admitted on 10/24/19, with diagnoses that included history of a stroke (damage to the brain from interruption of its blood supply), cognitive psychotic disorder (a brain disorder that causes unusual shifts in mood, energy, activity levels), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and cellulitis (infection under the skin, which usually enters through a cut or sore; characterized by reddened, warm skin) on lower legs. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 10/31/19, indicated Resident 118's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was moderately impaired for daily decision making. The MDS indicated the resident required total assistance with transfer, and extensive assistance with dressing, toileting, bathing and eating. A review of Resident 118's interdisciplinary team ([IDT] a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) meeting notes, dated 10/24/19, indicated the resident had a history of refusing medications and treatments by refusing to see a wound consultant, and repeatedly refused treatment on the wounds. A review of Resident 118's Social Service review notes, dated 10/29/19, indicated the resident had	F 656	was developed, reviewed, revised and implemented. The DON will report the findings monthly to the QA committee for evaluation and further recommendations for the next three months. Policy effectiveness will be discussed at the monthly and quarterly QA committee meeting as part of survey review.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 6 episodes of refusing medication/treatment, and refusing showers/wound care. During an observation on 11/07/19 at 3:10 PM, Resident 118 was lying in bed. An attempt was made to interview Resident 118, however, the resident refused and placed a towel over his head. During an observation on 11/08/19 at 10:21 AM, Resident 118 refused to allow licensed Vocational Nurse (LVN 4) to change the wound dressing on the leg. LVN 4 stated the resident often refused wound treatments, which made the staff come back and offer care and treatments at another time. LVN 4 stated sometimes the resident agreed and other times did not allow the care to be provided. During an interview and record review on 11/14/19 at 7:23 AM, the Director of Nursing (DON) reviewed Resident 118's care plans and was unable to find any care plans that addressed the refusal of care or treatments. The DON stated Resident 118 was non-compliant at times due to his psychiatric diagnosis and acknowledged the resident's behaviors could impede care at times. When asked if there should be a care plan for Resident 118's episodes of non-compliant and refusing care and treatments, DON stated, "Yes, we usually have one for that. I don't know what happened, I think he used to have one for that when he was here before." DON looked through the Resident 118's electronic medical records again and stated, "I don't see anything here." DON stated they would create a care plan for Resident 118 today. A review of the facility's undated policy and	F 656		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 7	F 656		

procedure, titled, "Care Plans, Comprehensive Person-Centered", indicated a comprehensive, person-centered care plan would be developed to include measurable objectives and timetable to meet the residents physical, psychosocial and functional needs.

A review of the facility's undated policy and procedure, titled, "Care Planning-Interdisciplinary Team", indicated the Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident.

A review of the facility's undated policy and procedure, titled, "Behavioral Assessment, Intervention and Monitoring", indicated the interdisciplinary team would evaluate behavior symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. The policy indicated the interventions would be individualized and part of an overall care environment that supported the physical, functional and psychosocial needs, and strive to understand, prevent or relieve the resident's distress or loss of abilities.

b 1. A review of Resident 79's admission record indicated the resident was admitted to the facility on 12/27/18 with diagnoses including but not limited to Alzheimer's disease (progressive disorder that causes brain cells to waste away) with vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with behavioral disturbance and history of transient ischemic attack (stoke lasting a few minutes), and cerebral infarction (lack of blood flow in the brain due to a

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 8	F 656		

blockage, resulting in severe damage to brain tissue) without residual deficits.

A review of Resident 79's Minimum Data Set (MDS), a standardized comprehensive assessment and care screening tool, dated 8/30/19 indicated the resident had moderate cognitive impairment (ability to think, understand and make daily decisions).

During a record review with the Minimum Data Set Nurse (MDSN 1) on 11/14/19 at 8:34 a.m., indicated an order dated 10/24/19 for Haldol (can treat certain types of mental disorders) was reduced from 1 milligram (mg), two times a day to 1 mg to be given at bedtime.

A review of Resident 79's care plan for vascular dementia indicated the resident had behavior disturbance manifested by striking out at staff for no apparent reason and was on an antipsychotic medication. The goal was for the resident to remain free of drug related complications through the review date. During a concurrent interview with MDSN 1, stated the resident care plans should be resident-centered. The MDSN 1 stated for the antipsychotic medication in this case, the goal should have included a decrease in episodes of striking out and to decrease the use of the antipsychotic medications.

b 2. During an observation and interview on 11/07/19 at 1:28 p.m., Resident 79 was awake but confused, and unable to answer questions. The resident was observed with the bed in low position, attempting to get up from bed by pulling his upper body forward.

During an observation on 11/13/19 at 12:58 p.m.,

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 9 Resident 79 was observed lying on bed, attempting to sit up. The pad floor mats were observed on each side of the bed. During a concurrent interview with Certified Nurse Assistant (CNA 2) , who was in the room, stated the resident had some confusion. CNA 2 stated the resident was able to move bilateral (both sides) upper extremities with minimal difficulty, was able to move lower extremities without assistance and was able to sit in a wheelchair. A review of Resident 79's admission record indicated the resident was admitted to the facility on 12/27/18 with diagnoses including but not limited to Alzheimer's disease (progressive disorder that causes brain cells to waste away) with vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with behavioral disturbance, history of transient ischemic attack (stoke lasting a few minutes), cerebral infarction (lack of blood flow in the brain due to a blockage, resulting in severe damage to brain tissue) without residual deficits and, history of falls. A review of Resident 79's Minimum Data Set (MDS), a standardized comprehensive assessment and care screening tool, dated 8/30/19 indicated the resident had moderate cognitive impairment (ability to think, understand and make daily decisions) for daily decision making. A review of Resident 79's care plans indicated a care plan for risk for repeated falls or injury related to confusion, gait and balance problems, incontinence, vision and hearing problems, history of fall, and risk for decline in range of	F 656		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 10	F 656		

motion due to dementia and Alzheimer's disease. The care plan goals was for the resident to be free of falls, minor injury and not sustain a major injury through the review period. The interventions included to anticipate the resident's needs and meet promptly and the resident and providing a safe environment.

During a record review of Resident 79's care plan for risk for fall indicated the care plan was last updated on 10/4/19. A post fall review record dated 9/27/19 indicated the resident was found on the floor in the activity room and was last seen sitting on his wheelchair prior to the fall.

During an interview with CNA 2 on 11/14/19 at 9:07 a.m., stated the resident had behaviors of attempting to get out of bed or stand up "once in a while". CNA 2 stated "that is why he has floor pads and we keep the bed in low position". CNA 2 stated when the resident tried to get up, the resident was redirected, cleaned up and get him up on his wheelchair and take him to the activity room for activities. CNA 2 stated we had not seen the resident fall "because during the mornings we take him to activities".

During an interview with the Activity Director (AD) on 11/14/19 at 9:34 a.m., stated she did not witness Resident 79's fall on 9/27/19. The AD stated activity assistants were responsible for supervising the residents in the activity room. The AD stated her staff were aware of Resident 79's risk for fall and stated "we usually sit him next to us and close so we can keep an eye on him. Sometimes we place a table in front of him so he can do table games." The AD stated "we monitor him and do sensory activities with him".

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 656	Continued From page 11 During an interview with the Director of Nursing (DON) on 11/14/19 at 10:35 a.m., stated Resident 79's fall in the activity room happened at 11 a.m.. The DON stated the internal investigation of the fall indicated indicated the residents were starting an activity when Resident 79 was witnessed by another resident standing up from his wheelchair before he fell on his side. The DON stated Activity Assistant (AA 1) was in the activity room at the time of the incident. During a concurrent review of Resident 79's care fall and risk for repeat fall care plans the DON stated there was no interventions specific to providing supervision for the resident during activities, other than anticipating his needs. The DON stated he will update the care plan. A review of an undated facility's policy titled "Care Planning, Interdisciplinary Team", indicated the facility interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care that adhered to accepted standards of clinical practice for two of 2 sampled residents (4, 48). A licensed staff was observed on two occasions, listening to Resident 4's apical pulse (number of	F 658		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 658	Continued From page 12 heart beats, assessed through a stethoscope placed over the heart) by placing a stethoscope over the resident's clothing. The medication administration nurse spilled Resident 25's medication while trying to administer them through a gastric tube ([GT] a tube passed through the stomach used in administering feeding to resident), resulting in the license staff not knowing the exact amount of medication received and the amount spilled. The licensed staff then administered another complete dose to the resident without consulting with her supervisor, and not notifying the primary physician of the incident, before administering another dose of medications to the resident. This deficient practice had the potential to result in capturing an inaccurate heart rate count for Resident 4, and not assessing Resident 25's spilled medications. This could lead to administering medications that could cause Resident 4's heart rate to decrease to a dangerously low rate, and creating complications for Resident 25. Findings: a. A review of Resident 4's admission form indicated the resident was originally admitted to the facility on 9/7/18 and re-admitted to the facility on 11/3/18, with diagnoses that included hypertension (high blood pressure), spondylosis with myelopathy (a progressive degenerative disease of the spinal cord, impairing function), and obesity (overweight).	F 658	**F658 – Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)** **CORRECTIVE ACTION** A: On 11/13/19, the DON completed a 1:1 counseling with Licensed Nurse (LVN-2) discussing accurate measuring of apical pulse, policy and procedure. B: On 11/13/19, the DON completed a 1:1 counseling with Licensed Nurse (LVN-7) discussing medication administration guidelines with emphasis on the facility's need to clarify with the primary physician accurate dosage. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** A: Shortly after discovery by the local department of health surveyor on 11/13/19, the DON and assistant DON (aDON) completed visual rounds check of charge nurses during medication pass and vital signs check throughout the day. No other residents were found similar affected by this deficiency. B: After discovery by the local department of health surveyor, the DON and aDON completed visual rounds check of charge nurses during medication pass focusing on those residents with gastro-tube administration. No medication admin errors found; No other residents were found similar affected by this deficiency. **SYSTEMIC CHANGES** A, B: The DON or clinical nurse consultant will conduct quarterly, or as-needed, in-services to licensed nurses discussing resident assessment (i.e. vital signs) and medication administration	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 658	Continued From page 13 The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/2/19, indicated Resident 4's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was intact for daily decision making. The MDS assessment indicated the resident required extensive assistance with transfer, dressing, toileting, bathing and supervision with eating. A review of Resident 4's physician order, dated 1/19/19, indicated to administer metoprolol tartate (medication for high blood pressure) tablet 50 milligram (mg), two times a day for hypertension and to hold the medication if the heart rate was below 60 beats per minute. A review of Resident 4's physician order, dated 5/25/19, indicated lisinopril (medication for high blood pressure) tablet 40 mg one time a day for hypertension and to hold the medication for pulse rate was less than 60 beats per minute. A review of Resident 4's Medication Administration Record (MAR), dated November 2019, indicated the resident received Lisinopril and Metoprolol every day. During an observation of medication pass on 11/13/19 at 7:35 AM and again at 8:26 AM for Resident 4, Licensed Vocational Nurse (LVN 2) checked Resident 4's apical pulse by placing her stethoscope directly over the resident's T-shirt. When asked what was the correct method to check the apical pulse, LVN 2 stated that was how she checked it. When asked if there was a facility policy on how to check the apical pulse, LVN 2 stated she did not know, but would try to find out.	F 658	guidelines reminding licensed nurses to contact the primary physician, if clarification is needed. This policy will be remaining in effect for the next three months. **MONITORING EFFECTIVENESS** The DON or designee will conduct skill competency checks on licensed staff upon orientation, randomly thereafter and at annual evaluations to ensure compliance with facility policies. This policy will be in place permanently. Policy effectiveness will be discussed at the monthly and quarterly QA committee meeting as part of survey review for the next three months.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 658	Continued From page 14 On 11/13/19 at 12:55 PM, LVN 2 presented an undated facility's policy titled, "Apical Pulse, Measuring". The policy indicated to place the stethoscope in a way that would touch the resident's skin. LVN 2 stated, "I learned something new today, I didn't know I was supposed to do that." b. A review of Resident 48's Admission Face sheet indicated the resident was initially admitted to the facility on 8/20/16 and re-admitted on 11/27/17 with diagnoses including respiratory failure with hypoxia (a condition where the airways that carry air to the lungs become narrow and damaged), hypoxia (low blood oxygen levels caused by hypoxemic respiratory failure) dependent on respirator ventilator [artificial breathing]), and dysphasia (difficulty swallowing). A review of Resident 48's Minimum Data Set (MDS), a standardized assessment and care -screening tool, dated 6/4/19 indicated Resident 48 did no have the ability to understand and be understood by others. The MDS assessment indicated Resident 48 required extensive assistance from staff with transfers, dressing, eating, toilet use, and personal hygiene. A review of Resident 48's History and Physical assessment form dated 6/18/19, indicated resident does not have the capacity to understand and make decisions. A review of Resident 48's Physician's orders dated 6/16/17 indicated the resident would receive Benztropine mesylate tablet ([cogentin] medication used to control seizure disorder) 0.5 milligram (mg) ordered to be given thru a GT, two times a day.	F 658		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 658	Continued From page 15 A review of Resident 48's Care Plan dated 9/26/17 indicated Resident 48 had diagnosis of seizure disorder. The interventions indicated to administer Benztropine mesylate tablet 0.5 mg thru GT, twice a day, monitor laboratory values, and report any sub-therapeutic or toxic results to the physician. A review of another Care Plan dated 11/13/19, indicated Resident 48 received additional Benztropine mesylate tablet. The interventions indicated to administer Cogentin 0.5 mg via GT, twice a day as ordered by the physician, monitor the resident for 72 hours for signs and symptoms of anticholinergic effects such as urinary retention, irregular pulse, increase in temperature, as a result of additional administration of medication dose to the resident. On 11/13/19 at 8:22 a.m.,during a concurrent observation and interview with Licensed Vocational Nurse (LVN 7) removed cogentin 0.5 mg, one tablet for convulsion disorder, and crushed it for administration to Resident 48. During administration of medication through GT, the cogentin medication spilled out on the towel. LVN 7 stated "I spilled some of the cogentin prescribed for the resident, I could not get all of the medicine inside for resident and that is a prescribed medicine. This is a medication error, I have to give the resident the medicine again because it spilled and I do not know the amount that spilled. I have to pour out the medication and give to resident again and let pharmacy know. This is a prescription medicine and now that it is spilled the resident may have convulsion. I have to monitor resident closely."	F 658		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 658	Continued From page 16 on 11/13/19 at 09:00 a.m., during observation LVN 7 removed another 0.5 mg, one (1) tab of cogentin, crushed it before administering it again to Resident 48. On 11/13/19 at 03:04 p.m., during interview Registered Nurse (RN 2) stated the facility called the pharmacy consultant to refill the used cogentin medication. RN 2 stated the staff were supposed to call the physician to notify the incident whereby the cogentin medication spilled during administration and clarify with the doctor the amount that was supposed to be given again. RN 2 stated the spilling of cogentin should be clarified by the doctor whether to continue to give another pill or not. During a concurrent interview LVN 7, stated "I was supposed to call the doctor and clarify if I should medicate resident again after the cogentin spilled before proceeding to medicate Resident 48 again with another complete dose of the medication." A review of facility's Policy and Procedure titled "Medication Administration - General Guidelines" dated 10/2017, indicated if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. The policy further indicated if a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or conditions, the nurse calls the prescriber for clarification prior to administration of the medication.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 17 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure five of 4 sampled residents, (58, 92, 75, 171, 219) received the treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan to meet each resident's physical, mental and psychosocial needs. Resident 92, and 75, who had edema (fluid retention), in the extremities, did not have the extremities elevated per the plan of care. Resident 171, who had moderate to severe pain levels, was not medicated per the physician's order. Resident 58, omeprazole DR (a delayed release medication, used to decrease the amount of acid produced in the stomach, prevent acid reflux, gastric ulcers and erosion of the esophagus which must not be crushed) was crushed prior to administration, which could potentially alter the effects of the omeprazole DR. Resident 219, who was unable to carry out the activities of daily living, prior to leaving the	F 684	**F684 – It is the policy of this facility to ensure, based on their comprehensive assessment, residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices.** **CORRECTIVE ACTION** a: On 11/09/19, the DON and charge nurse reassessed Resident-92's extremities with follow-up contact made with the primary physician. No new orders were given. On 12/11/19 the clinical nurse consultant conducted in-services for licensed nurses emphasizing raising of the extremities for those residents with diagnosed edema. b: On 11/07/19, the DON and charge nurse reassessed Resident-75's extremities edema with follow-up contact made with the primary physician. No new orders were given. On 12/11/19 the clinical nurse consultant conducted in-services for licensed nurses emphasizing raising of the extremities for those residents with diagnosed edema. c: On 11/08/19, the DON and assistant DON (aDON) reassessed Resident-171 for pain and the care plan was reviewed and updated by the DON and MDS staff, with clarification made with the primary physician addressing intervention for	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 18 resident for a break, the staff did not provide a blanket to keep the resident warm during an incontinence episode. These deficient practices had the potential to result in Resident 58, 92, 75, 171, 210, and 219 not recieving the quality of care when needed. Findings: a. During an observation, Resident 92, who had edema in both hands was observed on 11/7/19 at 11:52 a.m. which was not elevated to decrease the swelling. On 11/7/19 at 12:11 p.m., during an observation and concurrent interview, Certified Nursing Attendant (CNA 10) stated "Residents 92 whose hands have edema should be elevated because of the inflammation. Elevating it will help lower the edema". On 11/8/19 at 12:22 p.m., during an interview, when questioned about Resident 92's edema on both hands, Licensed Vocational Nurse (LVN 15) stated "Swollen extremities of residents should be elevated with pillows. We have to elevate them higher than the heart so that the fluids retained will go down. I know they do sometimes move, but we do need to put them back on the pillows. If we notice any difference from the last time, we have to notify the physician". On 11/12/19 at 4:31 p.m., during an interview, CNA 6 stated "For residents who has edema, we have to elevate the affected area right away with pillow and if it's new, I will tell the supervisor right	F 684	pain and oxygen administration. d: On 11/08/19, the DON and charge nurse reassessed Resident-58 for any abnormal vital signs. Resident-58 vital signs were within normal range. From 12/03/19 to 12/06/19, the DON conducted in-services to licensed staff discussing medication administration guideline policy and procedures with emphasis on delayed release medication. New PDR 2020 Edition Nurses' Drug Handbook were delivered to the facility by the pharmacy on 11/13/19. e: On 11/07/19, the DON assessed Resident-219 with follow-up contact made with the primary physician. No new orders were given. From 12/03/19 to 12/06/19, the DON conducted in-services to licensed staff discussing resident quality of care, proper response times with residents' needs and ensuring all the residents requests are handled promptly. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** a., b.) On 11/08/19 the DON, RN supervisor and aDON assessed all other residents with edema present in their extremities ensuring proper elevation of diagnosed body parts. No other residents were found similarly affected by this deficiency. c.) The DON, medical records and MDS assessed all other residents with pain management and prescribed or routine oxygen. No other residents were found similar affected by this deficiency. d.) On 11/12/19, the DON and aDON assessed	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 19 away". During a review of the clinical records on 11/8/19 at 1:20 p.m., the Minimum Data Set (MDS) a comprehensive assessment and care planning tool) dated 10/9/19 indicated Resident 92's brief interview of mental status, had short- and long-term memory problems and severely impaired cognitive skills for daily decision making, and was totally dependent for bed mobility. The MDS assessment indicated Resident 92's diagnosis included but not limited to, generalized edema (fluid accumulation that affects the whole body), respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide to reach the heart, brain, or the rest of the body that can cause symptoms such as shortness of breath), ventilator dependent (use of machine- ventilator (or respirator) that helps someone breathe and keeps oxygen flowing throughout the body by pushing air into the lungs), tracheostomy (surgical opening in the neck airway to establish airway), gastrostomy (surgical opening in the stomach for feeding purposes) status. A review of Resident 92's care plan initiated 7/1/19 indicated that resident was dependent on staff for activities of daily living, had physical limitations and anasarca (general swelling of the whole body that can occur when the tissues of the body retain too much fluid). Resident 92's care plan also indicated a generalized edema which was initiated on 10/20/19, and revised on 11/7/19, indicating for staff to elevated upper and lower extremities using pillows. b. During an observation, Resident 75, who had edema (fluid retention) on the right hand was	F 684	all other residents with delayed release medication prescribed. No other residents were found similarly affected by this deficiency. e.) On 11/12/19, the DON, assistant DSD and social services designee (SSD) assessed all other residents for similar type concerns. No other residents were found similarly affected by this deficiency. **SYSTEMIC CHANGES** The DON or clinical nurse consultant will conduct quarterly, or as-needed, in-services to licensed nurses discussing resident assessment and medication administration guidelines reminding licensed nurses to contact the primary physician, if clarification is needed. This policy will be remaining in effect for the next six months. **MONITORING EFFECTIVENESS** The DSD and DON or designee will conduct skill competency check on licensed staff upon orientation, randomly thereafter and at annual evaluations to ensure compliance with facility policies. This policy will be in place permanently. Policy effectiveness will be discussed at the monthly and quarterly QA committee meeting as part of survey review.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 20 observed on 11/7/19 at 11:58 a.m., which was not elevated to decrease the swelling. During a review of the clinical records on 11/8/19 at 2:20 p.m., the Minimum Data Set (MDS), a comprehensive assessment and care planning tool, dated 9/27/19 for Resident 75 indicated the resident was totally dependent on staff for bed mobility. A review of the MDS assessment indicated Resident 75's diagnosis included but not limited to, respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide to reach the heart, brain, or the rest of the body that can cause symptoms such as shortness of breath), ventilator dependent (use of machine that helps someone breathe and keeps oxygen flowing throughout the body by pushing air into the lungs), tracheostomy (surgical opening in the neck airway to establish airway), gastrostomy (surgical opening in the stomach for feeding purposes) status, obesity (overweight), and kidney disease (longstanding disease of the kidneys leading to renal failure). A review of the admission nursing data for Resident 75 dated 9/21/19 did not indicate the resident had edema on the admission. A review of Resident 75's care plan initiated on 9/2619 indicated the resident had kidney disease and one of the interventions was to monitor for signs and symptoms of dependent edema. c 1. During a review of the clinical records for Resident 171 on 11/8/19 at 8:24 a.m., the medication administration record (MAR) indicated the resident was given Norco (narcotic pain medicine) 5-325 milligram (mg), one tablet for	F 684		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 21	F 684		

pain level of 8 out of 10 on a pain rating scale (on a numeric pain rating scale, zero meaning no pain and 10 meaning the worst pain experienced).

A review of Resident 171's medication administration record (MAR) for November 2019 indicated a scheduled Norco 5-325 mg, one tablet every 6 hours for mild pain. A review of the MAR dated 11/7/19 at midnight, indicated Resident 171 had a pain level of 10 out of 10 on a pain rating scale, and at 6 p.m., the resident experienced a pain level of 8 out of 10 on a pain rating scale. On 11/8/19 at midnight, MAR indicated Resident 171 had a pain level of 8 out of 10, and at 6 a.m., the pain level was 8 out of 10.

The MAR for November 2019 indicated an order of Norco 5-325 mg., give 2 tablets via gastric tube (a tube surgically placed in the abdomen to deliver medications and nutrients), every 6 hours as needed for moderate pain (4-6 out of 10) and severe pain (7-10 out of 10). However, Resident 171 did not receive the amount of Norco medications ordered as needed for experiencing moderate and or severe pain level.

On 11/8/19 at 12:13 p.m., during an interview and concurrent record review, Licensed Vocational Nurse (LVN 15) confirmed one Norco 5-325 mg tablet was given to Resident 171 on 11/8/19 midnight for the pain level of 8 out of 10. LVN 15 stated "when we give pain medication, we click the MAR, document the pain level and the number of tablets given. As soon as when we document that, everything is populated in the progress notes".

On 11/12/19 at 11:06 a.m., during an interview,

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 22	F 684		

LVN 16 stated "The numerical pain levels for mild pain is 1-3, moderate pain is 4-6 and severe is 7/10. When I give an as needed pain medicine, we assess for the level of pain. If the patient is verbal, they are able to tell us their pain level. We go by what is ordered. We reassess the pain level after 40-45 minutes after administration."

On 11/12/19 at 11:11 a.m., during an interview and concurrent record review, Registered Nurse (RN 3) confirmed Resident 171 was given one tablet of Norco on 11/8/19 midnight for 8 out of 10 pain level. RN 3 stated "Resident 171 should have been given two tablets instead.

On 11/12/19 at 11:20 a.m., during an interview and record review, medical records personnel (MR), stated "When nurses clicked the MAR, it documents the given PRN medication (given as needed) and will populate to the progress notes. It should indicate "emar administration note".

On 11/12/19 at 11:22 a.m., during an interview, RN 3 stated "Resident 171 should have received 2 tablets that time since he complained of 8 out of 10 pain level. The routine pain medicine was only 1 tablet and there was a prn order for Resident 171's pain level of 8 out of 10."

A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 11/5/19 indicated Resident 171's brief interview of mental status (BIMS screens for cognitive impairment) score of 6 (a score of 0-7 indicates severe cognitive impairment with daily decision making), received hospice care (care for terminally ill with 6 months or less to live), and was on oxygen therapy. Resident 171's diagnosis included, but was not limited to, alcoholic

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 23	F 684		

cirrhosis of liver (a chronic disease of the liver marked by degeneration of cells, inflammation, and fibrous thickening of tissue), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection).

A review of an undated facility's policy titled "Pain Assessment and Management", indicated pain management is the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multi-disciplinary care process that includes assessing the potential for pain, effectively recognizing the pain, developing and implementing approaches to pain management, modifying approaches as necessary.

c 2. During an observation on 11/7/19 at 11:00 a.m., Resident 171 was observed using oxygen at 3 liters per minute via nasal cannula (LPM/NC). Resident 171 was observed having difficulty breathing.

During a clinical record review on 11/8/19 at 8:26 a.m., the physician order as of 11/13/19 indicated Resident 171 was admitted under hospice care on 10/31/19, an ordered to check oxygen saturation levels (amount of oxygen in the blood) every shift and an oxygen at 2-3 LPM/NC as needed for shortness of breath (SOB) ordered on 10/30/19.

A review of Resident 171's Medication administration Records (MAR) for November 2019 did not indicate oxygen was administered when needed.

On 11/8/19 at 8:35 a.m., during an observation

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 24	F 684		

and concurrent interview, the hospice personnel (HP) was observed providing care to Resident 171. HP confirmed Resident 171 had been on continuous oxygen therapy.

On 11/8/19 at 12:22 p.m., during an interview, Licensed Vocational Nurse (LVN 15) stated the facility had the same standards in monitoring hospice patients as with the other patients.

On 11/8/19 at 12:35 p.m., during a clinical record review and concurrent interview, LVN 15 stated Resident 171's physician order indicated to administer oxygen 2-3 LPM/NC as needed. LVN 15 stated "So, if the resident is having a SOB, we administer the oxygen. If the patient only needs it on an as needed basis, we stop the use when the resident gets better. If the resident would need it continuously, I would do the proper assessment and call the doctor and let him know that the patient needs it continuously."

On 11/8/19 at 12:41 p.m., during an interview, Respiratory Therapist (RT 10) stated "oxygen administered to the resident at the bedside has to match with the physician's order".

On 11/9/19 at 2:40 pm., during review of Resident 171's clinical records indicated the oxygen therpay that was ordered prn was discontinued and changed to continuous for comfort measures.

According to an undated facility's policy titled "Oxygen Administration", indicated to verify and review that there is a physician's order for oxygen administration, review the resident's care plan to assess for any special needs of the resident. After completing the oxygen set up or adjustment,

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 25	F 684		

the frequency and duration of the treatment, the reason for prn administration, all assessment data obtained before, during and after the procedure and how the resident tolerated the procedure should be recorded in resident's medical record.
d. A review of Resident 58's admission form indicated the resident was originally admitted to the facility on 8/24/13 and re-admitted to the facility on 4/17/19, with diagnoses that included gastrostomy tube ([GT], a tube surgically inserted through the skin into the stomach for feeding and medication administration), gastro-esophageal reflux disease ([GERD] disease in which the stomach contents leak backwards from the stomach into the esophagus) aphasia (a disorder caused by damage to the parts of the brain that control language), and dementia (a group of thinking and social symptoms that interferes with daily functioning).

The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 9/9/19, indicated Resident 58's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was severely impaired for daily decision making. The MDS indicated the resident required total assistance with transfer, dressing, toileting and extensive assistance with bathing and eating.

A review of Resident 58's physician order, dated 9/26/19, indicated to administer omeprazole capsule DR, 20 milligrams (mg) via GT one time a day for diagnosis of GERD.

A review of Resident 58's physician order, dated 4/17/19, indicated may crush all crushable medications.

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 26 A review of Resident 58's Medication Administration Record (MAR), dated November 2019, indicated the resident received omeprazole capsule DR every day. During an observation of medication pass on 11/12/19 at 9:18 AM, Licensed Vocational Nurse (LVN 1) prepared Resident 58's medications, with omeprazole capsule DR for administration, then stated, "Can I start crushing my meds." LVN 1 was asked if all the medications were crushable, LVN 1 stated, "Yes." LVN 1 proceeded to crush all the medications inlcuding omeprazole capsule DR and proceeded to administer the medication. However, when asked what the initials 'DR' meant on the omeprazole label, LVN 1 paused, then went back to the computer on top of the medication cart, and stated, "Oh, DR means delayed release." When asked what DR meant, LVN 1 hesitated and then stated, "um, can I find out. I don't want to guess and give you the wrong answer." Then LVN 1 stated, "Can I give the meds first, then ask about it afterwards." LVN 1 decided to lock the crushed omeprazole inside the medication cart and continued to give the other medications. After finishing medication pass for Resident 58, LVN 1 stated she usually goes to the nurse consultant or Director of Nursing (DON) for questions, then proceeded to walk to the DON's office. When the DON was asked what DR meant, the DON stated it stands for delayed release. When asked what does that mean, the DON hesitated. Then when asked, if a nurse was supposed to crush a medication that was marked DR, DON stated, "No." When asked why not, DON stated omoparazole was supposed to be released over a period of time and crushing it would alter the effects of the medication. When	F 684		

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 _____	11/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY 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
F 684	Continued From page 27 asked what source the nurses should use to look up medications, the DON stated LVN 1 could have used Google search engine, then stated they also have a drug book at the nurses' station. Next, LVN 1 went to the drug book at the nurses' station and looked up omeprazole, which indicated it was a DR medication. When asked if the facility had a 'Do Not Crush' list of medications, LVN 1 stated, "Oh yeah, it's on our med cart." LVN 1 went back to the medication cart and pulled out the "Do Not Crush List" and looked at the list, then stated, "Oh, yeah, here it is, we aren't supposed to crush it." A review of the facility's policy and procedure, titled, "Medication Administration-General Guidelines", dated 10/2017, indicated medications were administered as prescribed in accordance with good nursing principles and practices. The policy indicated long-acting or enteric coated dosage forms should generally not be crushed and an alternative should be sought. The policy also indicated that liquid dosage forms may be a practical alternative and the nurse should check with the pharmacy to determine if a liquid form was available. A review of the facility's nursing drug book, titled, "PDR 2013 Edition Nurses' Drug Handbook", indicated that omeprazole was supplied in a delayed-release capsule and suspension (liquid). The book only addressed a suspension form of omeprazole may be given via gastric (GT) route. A review of the omeprazole package insert, provided by the facility, dated 9/2012, indicated the medication was delayed-release and that it was available in suspension (liquid) form.	F 684		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 28	F 684		

A review of the facility's "Do Not Crush Medication List", dated 1/31/08, indicated that prilosec (omeprazole) was a slow release medication and should not be crushed.

e. A review of Resident 219's Admission Face sheet indicated the resident was initially admitted to facility on 11/24/17 and readmitted on 11/5/19 with diagnoses including heart failure, difficulty in walking, retension of urine, and urinary tract infection.

A review of Resident 219's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/5/19 indicated the resident had the ability to understand and be understood by others and needed assistance with all activities of daily living.

A review of Resident 219's Care Plan dated 11/6/19 indicated the resident was at risk for fall injury related to confusion, and lack of coordination. The Care Plan interventions indicated to anticipate and meet the resident's needs, call light within reach, encourage the use of the call light for assistance as needed, and prompt response by staff to all requests for assistance.

On 11/7/19 at 1:32 P.M., during observation and interview Resident 219 stated during the night of 11/6/19 had a bladder and bowel movement and the Certified Nurse Assistant (CNA) assigned to her was cleaning her up, but she was very cold. According to Resident 219, the CNA assigned, used one sheet to cover her and stated she needed to go for lunch break. Resident 219 stated she requested CNA to bring a blanket to cover her because she was feeling very cold and did not want to get sick from the cold air, but CNA

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 29	F 684		

left the room and did not come back to her. Resident 219 stated she waited and called on the call light and no staff responded to her call for over five hours, before the CNA return to her.

On 11/12/19 at 3:07 P.M., during interview CNA 3 stated "I have been working in the facility for about 1 year. I work every Wednesday and Thursday 3- 11 P.M shift. When I'm taking care of residents and need a break I usually inform the charge nurse that I am on my break. When I go on my break, I do let other staff know so that they can watch for my residents. My break is half an hour. my break starts 7 to 7:30 p.m. Then I do have 10 minute break at 4:40 P.M." CNA 3 stated "When I took care of Resident 219 last week Wednesday 11/6/19 and I change her and put her on the bed. I covered resident with a sheet. That day she told me that she was feeling cold. I told her that I will cover with a sheet when I finished. I told resident that I will be going on my my break but will come back, but I did not come back to the resident because it was very busy and so many call lights, so I went to answer the call light. She told me that she needed another sheet because she was very cold that day but, it was very busy I used the one in her room to cover her, I could not bring any other sheet to cover resident. In the future, I will make sure that I get whatever the patient ask for right away, because we are here to make sure they are comfortable and feels at home. if resident feels cold they can get sick and becomes uncomfortable."

On 11/12/19 at 03:24 P.M., during interview Licensed Vocational Nurse (LVN 2) stated "I do make sure the CNA's attend to the residents need. during medication administration. I do observe the residents and attend to their need. I

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 684	Continued From page 30 was not aware when Resident 219 was asking for extra blanket because CNA 3 was with the resident in the room helping her. If a resident request for extra blanket the CNA should prioritize her need by providing a blanket to resident before going to break or let me know so that I can help the resident while she is on break but she did not let me know." A review of facility's undated Policy and Procedure titled Activities of Daily Living (ADL) indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The policy indicated residents who are unable to carry out activities of daily living independently will receive the service necessary to maintain good nutrition, grooming, personal and oral oral hygiene, and mobility.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, an record review, the facility failed to implement interventions to reduce hazards and risks during resident care, for three of 3 sampled residents (65, 79, 92).	F 689	**F689 – It is the policy of this facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** **CORRECTIVE ACTION** a. On 12/11/19, the clinical nurse consultant completed an in-service to IDT members discussing residents assessed high fall risk need two-person assist during bed mobility and transfers. b. Cross reference with F-656. On 11/15/19, Resident-79's care plan was reviewed and updated by the DON and MDS staff addressing supervision of the resident while in the Activity room due to risk for fall. c. From 12/03/19 to 12/06/19, the DON conducted in-services to licensed staff emphasizing resident neurological check must be completed, post-fall to determine any changes after a possible head injury. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** a. On 11/08/19, after the local department of health surveyor finding, the DON and medical	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 31 Resident 65, who had a diagnosis of spastic hemiplegic cerebral palsy (a physical impairment and shaking at times that affects the development of movement, one side of body may be contracted), fell from the bed to the floor while staff was providing incontinence (lack of control over urine and bowel) care. Resident 79, the plan of care did not include specific interventions on how to provide supervision to the resident during activities, other than anticipating his needs, prior to a fall in the activity room. Resident 92, who sustained a fall was not assessed for neurological functions (used to assess an individual's neurological functions and level of consciousness in order determine any changes after the head injury), such as monitoring for nausea and vomiting and level of unconsciousness. This deficient practice potentially caused Resident 65 to sustain a fracture to her right clavicle (shoulder bone), Resident 79 falling out of the wheelchair in the activity room without a plan of care interventions specific to monitoring while in the activity room, and Resident 92 sustained a fall but there was no neurological checks to ensure the resident would not suffer from consequences of head injury. Findings: a. A review of Resident 65's admission form indicated the resident was originally admitted to the facility on 12/12/16, with diagnoses that	F 689	records staff reviewed all other residents assessed as high risk for falls to ensure two-person-assist was care planned. No other residents were found similarly affected by this deficiency. On 11/12/19 to 11/15/19, the assistant DSD and Administrator randomly monitored CNAs during resident transferring/bed adjustment. No other residents found similarly affected by this deficient practice. b. The DON, medical records staff and MDS reviewed other resident care plans that address monitoring of residents in general occupancy areas that are assessed high-risk for falls. As there were no other similar fall scenario findings that occurred, no other residents were found similarly affected by this deficiency. From 12/03/19 to 12/06/19, the DON conducted in-services to licensed staff regarding resident behavior concerns and accurate following of the resident's care plan to ensure prevention of injuries. c. On 11/12/19, after the local department of health surveyor finding, the DON and medical records staff reviewed previously documented resident falls to ensure neurological checks were properly completed. No other residents were found similarly affected by this deficiency. **SYSTEMIC CHANGES** The DSD will conduct skill competency check on CNAs and RNAs upon orientation, randomly thereafter and at annual evaluations to ensure compliance with safe resident transfer policies. This policy will be in place permanently. Continued daily rounds by department heads and staff of resident rooms and general	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 32 included spastic hemiplegic cerebral palsy (a physical impairment that affects the development of movement, one side of body may be contracted), polymyositis (inflammatory disease that causes muscle weakness affecting both sides of the body), and dementia (a group of thinking and social symptoms that interferes with daily functioning). The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 9/20/19, indicated Resident 65's cognition (mental capacity to make decisions, ability to remember, learn, and understand) with daily decision making was severely impaired. The MDS indicated the resident required total assistance, by one person, with transfer, dressing, toileting, bathing and eating. A review of Resident 65's quarterly fall risk assessment, dated 9/20/19 (prior to fall), indicated the resident was at risk for falls. A review of Resident 65's Psychiatric Evaluation notes, dated 9/19/19 (prior to fall), indicated the resident exhibited symptoms of cerebral palsy with uncontrolled body movements, thought process was illogical, insight and judgement was poor, and the resident was confused. A review of Resident 65's fall care plan, dated 12/13/16 and revised on 9/19/19, indicated the resident was at high risk for fall/injury, related to confusion, incontinence (unable to control bladder or bowels), poor communication/comprehension, unaware of safety needs, poor body alignment, and diagnosis of cerebral palsy. A review of Resident 65's care plan for Activities	F 689	occupancy areas will be completed to monitor/ those residents assessed as high risk for falls. The DON or his designee will complete follow-up documentation regarding a resident's 72-hour neurological check findings. On a quarterly basis, or as needed, the Interdisciplinary Team (IDT) will review resident care plans, especially those residents assessed as high risk for falls. **MONITORING EFFECTIVENESS** During room rounds, licensed nurses and department heads will randomly monitor CNAs or RNAs during bedside care, resident bed transfers/adjustments to ensure proper and safe technique as to avoid injuries to residents and staff. Any findings of noncompliance will be reported to the DON, DSD or Administrator for immediate coaching corrections. Any findings of repeat noncompliance will result in personnel write-up, room assignment changes or additional actions by the Administrator. At daily department head stand-up meetings, staff will discuss all monitoring of assigned resident rooms for cleanliness and any immediate corrections made. Any further trends seen regarding resident monitoring will be discussed at the monthly and quarterly QA meeting for suggestions or policy revision.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 33	F 689		

of Daily Living (ADLs), dated 12/13/16, indicated the resident needed total care for all ADLs.

A revision made to the care plan on 10/4/19 (after the fall), indicated to handle the Resident 65 gently and two persons were needed to assist during bed mobility and transfers.

A review of the General Acute Care Hospital (GACH) discharge notes, dated 10/3/19, indicated Resident 65 came to the emergency room with a bump on the head and a right clavicle (collarbone) fracture. Resident 65 returned to the facility with the right arm in a sling.

A review of Resident 65's interdisciplinary team [IDT] a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) meeting, dated 10/3/19 (post-fall), indicated Resident 65 was well-known by staff with a medical history of cerebral palsy, and was known by staff with an involuntary movement/fidgeting (move her head or shoulder left to right repeatedly) when in bed. The IDT notes indicated recommendations included using two persons to assist during bed motility and care to prevent future falls.

During an observation on 11/7/19 at 3 PM, Resident 65 was lying in bed, with a sling on her right arm. The resident's bed was in low position and there were floor mats on the side of the bed. An attempt was made to interview the resident, however, the resident did not respond.

During an interview and record review on 11/08/19 at 10:44 AM, the Minimum Data Set nurse (MDSN 2) reviewed Resident 65's medical record and stated the resident had a fall on

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 34	F 689		

10/1/19. When asked what happened, MDSN 2 stated while care was being provided when staff was changing the resident, the resident had an involuntary movements, which caused the resident to roll out of the bed.

During an interview and record review of the facility's fall investigation for Resident 65, the Director of Nursing (DON) presented the facility's fall investigation notes on the computer. The DON stated according to the facility's report, Certified Nursing Assistant (CNA 1) was changing Resident 65, she turned Resident 65 on her side and as CNA 1 loosened her grip on the resident to reach for her clean linen and diaper (which was located at the end of the bed) the resident got restless, rocked and fell to the floor before CNA 1 could catch her. The DON stated nursing staff assessed Resident 65 after the fall, however, it was not until the next day (10/2/19) that they noticed some swelling on the right shoulder. DON stated an x-ray found there was a fracture to the Resident 65's right shoulder. DON stated after the x-ray, the resident was transferred to a hospital for further evaluation. DON stated Resident 65 returned to the facility in less than 24 hours. When asked what did the facility determine was the cause of the fall, DON stated the resident had an involuntary movements and the staff had mentioned the resident get fidgety when they had provide care. The DON stated the interdisciplinary team ([IDT] a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) met to discuss the incident and decided to add another person during the care, so there would be two persons to assist with ADLs and moving Resident 65.

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 35 During an interview on 11/08/19 at 2:39 PM, when asked how did Resident 65 fall, CNA 1 stated she was changing Resident 65 and resident shook a lot, so CNA 1 kept her hands on the resident. CNA 1 stated during care she eased up a little to reach the clean linen and diaper at the end of the bed and by the time she took the roll of supplies, the resident fell out of the bed. CNA 1 stated, "It happened so fast, she just fell, I don't know exactly how she did it." When asked if there was supposed to be two persons to move the Resident, CNA 1 stated that she did not have another person there to assist her because the resident was so small and that's why they had been using only one person to change her." CNA 1 stated after the fall incident happened, now the facility uses two people to move Resident 65, in case the resident starts having shaky movements again. During an interview on 11/08/19 at 2:55 PM, Registered Nurse (RN 1), stated CNA 1 informed her when Resident 65 fell. RN 1 stated CNA 1 had told her she was cleaning the resident, the resident got fidgety, and as CNA 1 was reaching for a new diaper, all of a sudden the resident rolled over and out of the bed. RN 1 stated she knew Resident 65 gets fidgety. RN 1 stated the fidgety behavior did not happen every day but, Resident 65 tends to become more fidgety during incontinence care because they are moving her. RN 1 stated when they learned Resident 65 had a fracture, they sent her to the Emergency Room (ER) for further evaluation. RN 1 stated the resident came back to the facility with a sling. During an interview on 11/12/19 at 7:11 AM, Licensed Vocational Nurse (LVN 6) stated, "I was in another room and the CNA called me and said	F 689		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 36	F 689		

the patient was on the floor." LVN 6 stated he did an assessment of Resident 65 and there was a bump on the resident's head. LVN 6 stated Resident 65's shoulder was not swollen at that time. LVN 6 stated him and CNA 1 put the resident back to bed and called for RN 1.
When asked what instructions he gave to CNAs when the residents are identified as high risk for falls, LVN 6 stated the care plan was in the computer and they also tell the CNAs about precautions like checking the resident every time they go by the room, placing the bed in a low position, and placing the residents in the middle of the bed, so they do not fall out of the bed.

During a concurrent interview and record review on 11/13/19 at 2:09 PM, the Director of Rehabilitation (DOR) stated the rehabilitation department (rehab) did a post-fall evaluation on Resident 65. DOR stated they were told the resident fell out of bed while CNA 1 was in the process of changing the resident. DOR stated functionally there were no changes in status for Resident 65.

A review of the facility's undated policy and procedure, titled, "Fall Risk Assessment", indicated that upon admission, the facility would assess a resident's risk for falls and identify underlying medical conditions that may increase the risk of injury from falls, and would evaluate functional and psychological factors that might increase fall risk which included excessive motor activity, continence, and cognition.
b. During an observation of Resident 79 on 11/07/19 at 1:28 p.m., the resident was awake but confused, unable to answer questions. The resident was observed with the bed in low position, and was attempting to get up from the

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 37 bed by pulling his upper body forward. During an observation on 11/13/19 at 12:58 p.m., Resident 79 was observed lying on bed, attempting to sit up. The floor mats were observed on each side of the bed. During a concurrent interview with Certified Nurse Assistant (CNA 2), who was in the room, stated the resident had some confusion. CNA 2 stated the resident was able to move bilateral (both sides) upper extremities with minimal difficulty, was able to move lower extremities without assistance and was able to sit in a wheelchair. A review of Resident 79's admission record indicated the resident was admitted to the facility on 12/27/18 with diagnoses including but not limited to Alzheimer's disease (progressive disorder that causes brain cells to waste away) with vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with behavioral disturbance and history of transient ischemic attack (stoke lasting a few minutes), cerebral infarction (lack of blood flow in the brain due to a blockage, resulting in severe damage to brain tissue) without residual deficits, and history of falls. A review of Resident 79's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/30/19 indicated the resident had moderate cognitive impairment (ability to think, understand and make daily decisions) for daily decision making. A review of Resident 79's care plans indicated a care plan for risk for repeat fall or injury related to	F 689		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 38	F 689		

confusion, gait and balance problems, incontinence, vision and hearing problems, history of fall, risk for decline in range of motion due to dementia, and Alzheimer's disease. The care plan goals was for the resident to be free of falls, minor injury and not sustain a major injury through the review period. The interventions included to anticipate the resident's needs and meet promptly and the resident and providing a safe environment.

During a record review of Resident 79's care plan for risk for fall indicated the care plan was last updated on 10/4/19. A post fall review record dated 9/27/19 indicated the resident was found on the floor in the activity room and was last seen sitting on his wheelchair prior to the fall.

During an interview with CNA 2 on 11/14/19 at 9:07 a.m., stated Resident 79 had behaviors of attempting to get out of bed or stand up "once in a while". CNA 2 stated "that is why he has floor pads and we keep the bed in low position". CNA 2 stated when the resident tried to get up, the resident was redirected, cleaned up, sat in the wheelchair and taken to the activity room for activities. CNA 2 stated she had not found him on the ground in the past. The CNA stated "because during the mornings we take him to activities".

During an interview with the Activity Director (AD) on 11/14/19 at 9:34 a.m., stated she did not witness Resident 79's fall on 9/27/19. The AD stated activity assistants were responsible for supervising the residents in the activity room. The AD stated her staff were aware of Resident 79, who was a risk for fall and stated "we usually sit him next to us and close so we can keep an eye on him. Sometimes he was sat at a table in front

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 39	F 689		

of him so he can do table games." The AD stated "we monitor him and do sensory activities with him".

During an interview with the Director of Nursing (DON) on 11/14/19 at 10:35 a.m., the DON stated Resident 79's fall in the activity room happened at 11 a.m.. The DON stated the internal investigation of the fall indicated the residents were starting an activity when Resident 79 was witnessed by another resident standing up from his wheelchair and fell on his side. The DON stated Activity Assistant (AA 1) was in the activity room at the time of the incident. During a concurrent review of Resident 79's care fall and risk for repeat fall care plans the DON stated there was no interventions specific to providing supervision for the resident during activities, other than anticipating his needs. The DON stated he will update the care plan.

During an interview with AA 1 on 11/14/19 at 10:39 a.m., the activity assistant stated she did not remember specific details regarding Resident 79's fall in the activity room. AA 1 stated she recalls assisting another resident when she heard a shout and when she looked up, saw Resident 79 on the floor. AA 1 stated she did not recall the Certified Nurse Assistant making her aware Resident 79 was in the activity room. AA 1 stated she did not have visual contact with the resident. AA 1 stated if she was aware the resident was in the room, she would seat him closer to her, where she could see him because he had a tendency of standing up. AA 1 stated the staff would re-direct him or attempt to calm him down and ask him to sit back on his chair if he were within visual distance.

STATEMENT DF DEFICIENCIES AND PLAN DF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTIDN	(X3) DATE SURVEY CDMPLETED
	056220	A. BUILDING _____ B. WING _____	11/14/2019

NAME DF PRDVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CDDE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 90201

(X4) ID PREFIX TAG	SUMMARY STATEMENT DF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATDRY DR LSC IDENTIFYING INFDRMATIDN)	ID PREFIX TAG	PRDVIDER'S PLAN OF CDRRECTIDN (EACH CDRRECTIVE ACTIDN SHDULD BE CRDSS-REFERENCED TD THE APPRDPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 During an interview with the Certified Nurse Assistant 13 (CNA 13) on 11/14/19 at 12:09 p.m., the CNA stated she did not take Resident 79 to the activity room on the day of the incident. CNA 13 stated, "we had nursing students and he placed in the back of the room". CNA 13 stated the students were responsible for telling the activity staff the resident was in the room. CNA 13 stated Resident 79 was "always with the activities person, seated next to them". CNA 13 stated Resident 79 and some other residents are at risk for fall, being close to the activities staff so they can be watched. During an interview with the DON on 11/14/19 at 12:13 p.m., the DON stated Resident 79 needed adequate supervision to prevent falls. c. During a review of the clinical record for Resident 92, the health status notes dated 1/24/19 at 11:40 a.m., indicated Resident 92 had been found on the floor, lying face down. On 11/12/19 at 3:11 p.m., during an interview and concurrent record review, the Director of Nursing (DON) stated the facility documentation indicated the incident was investigated. The DON reviewed the clinical records indicated Resident 92's skull and left orbit (eye) was xrayed, which was negative for fracture (broken bones). The DON stated the facility determined the resident needed low bed and floor mats as part of new interventions. DON stated Resident 92 had the potential for head injuries, and after the fall the staff had to conduct neuro checks (used to assess an individual's neurological functions and level of consciousness in order determine any changes after the head injury), such as monitoring the resident for nausea and vomiting and level of unconsciousness. However, the DON	F 689		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 41 stated that was not done. On 11/13/19 at 1:16 p.m., during an interview and record review, DON stated there was no documentation that a neurochecks was done to ensure Resident 92 had not sustained a head injury. On a concurrent record review with the DON, the admission Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/16/19 indicated Resident 92 required 2 persons assist with bed mobility, dressing, toilet and personal hygiene. The DON also stated Resident 92 was non-verbal and did not understand anything. On 11/13/19 at p.m., during an interview, CNA 12 stated "I don't remember what exactly happened, because it has been like almost a year ago. I remember that Resident 92 started coughing, I put the call light on, and nobody came because I was fixing pillows from his foot at that time. So, I stepped outside the doorway, luckily the charge nurse was across the hall. So, she came to the room but when I went back in, the resident was already on the floor. CNA 10 was with me to help during the care but she had already left because I did not need her anymore. She helped me with the patient care and then with the pull up. The resident was left alone in the room by himself when I left to call for the charge nurse. CNA 12 stated there was no bleeding, but there was something on Resident 92' face. The charge nurse checked the resident's body and we used a hoyer lift to put him back to bed. He did not have any changes. The eye brow had redness, I think that's it." A review of the fall risk assessment dated 1/25/19, indicated Resident 92 was at risk for	F 689		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 689	Continued From page 42 falls. A review of the care plan initiated on 1/21/19, indicated Resident 92 was at high risk for fall/injury. The interventions indicated to use a low bed, and to always maintain proper a body alignment. During a review of the clinical records on 11/8/19 at 1:20 p.m., the Minimum Data Set (MDS a standardized assessment and care planning tool, dated 10/9/19 indicated Resident 92 had short- and long-term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS assessment also indicated the resident was totally dependent on staff for bed mobility. A review of Resident 92's face sheet indicated the diagnoses included but not limited to, generalized edema (fluid accumulation that affects the whole body), respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide to reach the heart, brain, or the rest of the body that can cause symptoms such as shortness of breath), ventilator dependent (use of machine that helps someone breathe and keeps oxygen flowing throughout the body by pushing air into the lungs), tracheostomy (surgical opening in the neck airway to establish airway), and gastrostomy (surgical opening in the stomach for feeding purposes) status. A review of an undated facility's policy titled, "Neurological Assessment", indicated neurological assessment is indicated following a fall or other accident/ injury involving head trauma.	F 689		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 695 F 695 SS=D	Continued From page 43 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the right replacement and size trache tube (breathing tube) at the bedside consistent with the physician's order, for one of 3 sampled residents (170). This deficient practice had the potential to cause an emergency crisis, when immediate access of the right trache type and size was needed, which could result in respiratory distress and death. Findings: During an observation on 11/7/19 at 11:52 a.m., Resident 170 had a green portex trache (type of trache) and a spare shiley trache (type of trache) at the bedside. During a record review, the physician order for November 2019 indicated there was an order for staff to change trach tube every month and as needed for Resident 170. The order indicated the	F 695 F 695	**F695 – Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)** **CORRECTIVE ACTION** On 11/08/19, after the local department of health surveyor finding, the respiratory therapist (RT-10) replaced the spare trache with the correct type shiley for Resident-170. From 12/03/19 to 12/06/19, the DON conducted an in-service for subacute licensed staff discussing policy and procedure for tracheostomy care with emphasis on providing the right replacement size trache tube at the resident bedside for immediate access. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The health and wellbeing of the subacute residents currently utilizing a ventilator and tracheostomy tube (breathing tube) could have been affected by this deficiency. On 11/08/19, the DON and subacute RN supervisor assessed	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 695	Continued From page 44 tracheostomy tube type was shiley 8, and cuff, un-fenestrated. On 11/8/19 at 1:04 p.m., during a concurrent observation and record review, Respiratory Therapist (RT 10) verified Resident 170 had a green color portex trache. However, RT 10 verified that place at the bedside, Resident 170 had a shiley 8 replacement trache. RT 10 stated portex size 9 was comparable to shiley number size 8 with the same size in diameter and a spare shiley size 6. During a concurrent record review, RT's flowsheet for November 2019 indicated Resident 170 had a shiley size 8. On 11/08/19 at 1:12 p.m., RT 10 accessed the central supply room which had a supply of green portex. RT 10 replaced the replacement trache for Resident 170 to the correct trache type shiley size 8, cuff, un-fenestrated. On 11/13/19 at 4:11 p.m., during an interview, RT 12 stated "we make sure spare trache is at the bedside. If a resident is admitted with a shiley, a spare shiley should be at the bedside". A review of the care plan initiated 10/29/19, indicated Resident 170 has a tracheostomy tube related to impaired breathing mechanics. The interventions included a tracheostomy tube portex 8 cuffed, unfenestrated, to keep extra trache and obturator at bedside. A review of Resident 170's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 11/5/19 indicated the resident had a diagnosis of anemia (deficiency of red blood cells or of hemoglobin in the blood, resulting in pallor and weariness), hypertension	F 695	all other subacute residents that receive respiratory tracheostomy care viewing for spare trache tube accessibility and correctness. No other residents were found similarly affected by this deficiency. **SYSTEMIC CHANGES** During daily rounds, the subacute RN supervisor and RTs will visually ensure the correct type and size spare trache tube is accessible at bedside. Any adverse findings will be corrected immediately with notification provided to the DON. **MONITORING EFFECTIVENESS** The DON or subacute RN supervisor will complete in-service training, quarterly and as needed, to licensed subacute staff discussing varying department policies and emphasis on tracheostomy care. This policy will remain in effect for the next three months. Any continued findings of room round deficiencies will be discussed at the daily department head stand-up meeting for immediate action as well as during the monthly and quarterly QA meeting at part of survey review for the next three months.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 695	Continued From page 45 (high blood pressure), respiratory failure (when the airways that carry air to your lungs become narrow and damaged and limits air movement through the body, which means that less oxygen gets in and less carbon dioxide gets out). A review of an undated facility's policy titled, "Tracheostomy Care", indicated that tracheostomy should be changed as ordered and as needed at least monthly. The policy also indicated a replacement tracheostomy tube must be available at the bedside at all times.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726	**F726 – Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)** **CORRECTIVE ACTION** The respiratory therapy (RT) consultant completed mandatory ventilator management certification training for subacute licensed nursing on 11/25/19 and 11/26/19. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** Upon discovery by the local department of health surveyor, the DON and subacute RN supervisor assessed all subacute residents with administered ventilator and tracheostomy tubing. No other residents were found affected by this vent certification deficiency. **SYSTEMIC CHANGES** The DSD will audit licensed staff personnel files on a semi-annual basis to ensure certification, training and licensing are valid and current. The	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 726	Continued From page 46 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure three licensed nursing staff members were current with appropriate competencies and skills sets to provide nursing and related services during ventilator (a machine designed to provide mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently) management, to assure the residents' safety. This deficient practice had the potential to not validate proper ventilator competencies for the licensed nursing staff, which could cause the resident's harm. Findings: During an interview and concurrent review of employee records on 11/12/19 at 3:58 p.m., the Director of Nursing (DON) stated "we do annual competencies evaluation and annual performance evaluations at the same time". On 11/13/19 at 4:11 p.m., during an interview, Respiratory Therapist (RT 12) stated "Skills competency are done every year. They reassess our skills with ventilator management every year.	F 726	DSD will immediately address expiring or expired certification by consultation with the clinical nurse consultant or DON or Administrator for suggestions. **MONITORING EFFECTIVENESS** The DON or DSD or clinical consultants will conduct skill competency checks on subacute licensed staff upon orientation, randomly thereafter and at annual evaluations to ensure compliance with facility policies and ability to provide necessary care for residents' needs. This policy will be in place permanently.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 726	Continued From page 47 RT consultant comes here to provide us with the recertification training". On 11/14/19 at 8:11 a.m., during the concurrent review of employee personnel files with the DON, it indicated the Registered Nurse (RN 10) had a ventilator management certification dated 8/15/18, Licensed Vocational Nurse (LVN 18) had a ventilator management certification dated 8/6/18, RT 13 had a ventilator management certification course dated 7/20/18. On 11/14/19 at 9:34 a.m., during an interview, DON stated "The annual performance evaluation we do for the staff are the same as for the annual competency checks. The annual performance evaluation is to evaluate the skills of the staff and after the evaluation, we continue to monitor the performance of the staff. Whatever the result is during the time of evaluation, education should be provided." A review of an undated facility's policy titled "Performance Evaluation", indicated that the job performance of each employee shall be reviewed and evaluated at least annually. The policy further indicated a written performance evaluations will contain the director's and/or supervisor's remarks and suggestions, any action that should be taken (e.g., further training, etc.) and goals.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.	F 744	**F744 – It is the policy of this facility to ensure a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being.** **CORRECTIVE ACTION** On 12/09/19, the clinical nurse consultant completed an in-service counseling to the IDT members discussing the importance of timely, quarterly Behavior Management assessment meetings to ensure all similar residents receive the appropriate treatment to attain/maintain their highest practicable well-being.	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 744	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure quarterly interdisciplinary team ([IDT] (a meeting where an interdisciplinary team, a group of healthcare providers from different fields, work together to discuss and plan the best care approach for the resident) behavioral management meeting for one of 1 sampled resident (72), who had dementia with behavior disturbance, was held on a quarterly basis. Resident 72, who had dementia with behavioral disturbances, did not have an IDT meeting held in the second quarter of 2019 to ensure the resident's needs were being met. This deficient practice had a potential to affect the overall outcome of Resident 72's behavioral management and wellbeing. Findings: On 11/12/19 at 2:38 PM during an interview, the social service director (SSD) stated that Resident 72 had a history of inappropriate behavior in sexual nature towards female staff and peers. A review of Resident 72's electronic medical record indicated the resident started to receive Risperdal (an antipsychotic medication to treat psychiatric conditions) 0.25 milligrams (mg) twice a day for restlessness on 2/25/19. On 6/4/19, Resident 72's Risperdal was changed to 0.25 mg every morning and 0.5 mg at bedtime for behavior control. On 9/23/19, the indication of use for the Risperdal medication orders were clarified	F 744	**IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The psychosocial well-being of the facility's residents would be affected if this deficiency was part of a widespread pattern. The social services department reviewed all other case management files, including quarterly behavioral management meetings and found no other residents were similarly affected by this deficiency. **SYSTEMIC CHANGES** Upon admission the DON or MDS staff or RN supervisor will assess the resident for dementia with behavioral disturbances with findings reported to the charge nurse, at change-of-shift endorsement and to the DON via the Communication dashboard. Assessments will continue quarterly for Interdisciplinary Team (IDT) care plan meetings and after any change-of-condition, as necessary. This policy will be in place permanently. **MONITORING EFFECTIVENESS** Resident care plans will be reviewed at the quarterly IDT meeting to ensure a comprehensive care plan is reflective of the resident's needs and interests. The clinical nurse consultant will conduct random resident chart audits on a quarterly basis to ensure compliance with facility policies and regulations. Audit results will be reported to the DON and Administrator for review. Any adverse findings will be addressed by the DON and discussed in the monthly and quarterly QA committee meeting as part of survey review.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 744	Continued From page 49 to dementia with behavior disturbance manifested by episodes of sexual inappropriate behavior towards staff/peers. A review of Resident 72's electronic medical record under IDT Behavior Management assessments notes indicated the type of assessment was documented as quarterly; however, there were only two IDT behavior meeting done in the past twelve months (January and September 2019). On 11/12/19 at 3:47 PM during an interview, the administrator indicated the IDT team meeting generally was to be held on a quarterly basis. The administrator confirmed there was no evidence of an IDT meeting for Resident 72 in the second quarter of 2019. A review of Resident 72's Quarterly Social Service reviews and IDT Behavior management reviews did not indicate any evidence a discussion, or sharing, of the Social Service findings. Also, there was no evidence that the IDT team had developed and implemented a person-centered non-pharmacological approach for Resident 72's behavior towards female staff and/or peers.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755	**F755 – It is the policy of this facility to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in $483.70(g).** **CORRECTIVE ACTION** a. The DON completed a 1:1 counseling with LVN-3 on 11/12/19 discussing the medication cart narcotic binder with emphasis on timely accurate log/record keeping of medication administration. On 12/11/19 the clinical nurse consultant completed an in-service to licensed nurses discussing the mandatory endorsement at change-of-shift medication logs and other essential communication items pertaining to nursing care.	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 755	Continued From page 50 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure out-going nurse (nurse who was finishing a work shift) performed and document the end of shift narcotic (controlled substances) inventory count with the incoming nurse (nurse who was starting a work shift). The facility also failed to ensure nurses completed the entries in the intravenous ([IV] through the veins) medication emergency kit (e-kit) log and medication disposition log, including the resident's name, date medication disposed, the name and strength of the medications, after removing medication from the e-kit and/or	F 755	b. From 12/03/19 to 12/06/19, the DON conducted an in-service to licensed staff discussing the narcotic count binder with emphasis on the controlled-drugs-inventory log and mandatory completion of the log at every change-of-shift by signature endorsement. c. From 12/03/19 to 12/06/19, the DON conducted an in-service to licensed nurses discussing medication storage room's emergency kit binders with overview of mandatory completion of all binder logs with accurate date, times, physicians' names and facility nurses that withdraw medication from the kits. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents with orders for narcotic or routine medication could have been affected by this deficiency if there were inaccurate logs of medication administration. After discovery by the local department of health surveyor, the aDON and medical records staff checked all medication carts, nurse station binders for inaccurate logs and found no other deficient items. No other residents were found affected by this deficiency. **SYSTEMIC CHANGES** Medical records office and the assistant DON (aDON) will conduct random audits of medication cart binders to ensure accurate/timely recordkeeping by nursing staff. This policy will remain effective for the next two quarters with review of effectiveness after every quarter. The DON or clinical nurse consultant will conduct quarterly in-services to licensed nurses reminding mandatory compliance of accurate and timely recordkeeping in all medication cart binders.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 755	Continued From page 51 disposing of the medications. These deficient practices had the potential of drug diversions and/or medication errors that may affect the residents' conditions. Findings: a. A review of the survey packet indicated the facility had two units, skilled nursing unit (SNF) and sub-acute unit ([SAU] unit that provides care more intensive than skilled nursing but less intensive than acute care such as hospital). On 11/12/19 at 11:52 AM during an inspection of the SNF medication cart 3, there was no narcotic accountability binder in the cart. During a concurrent interview, the licensed vocational nurse (LVN 3) stated she left the binder in the nursing station. When asked how she would document the removal of narcotics on the count sheet before medication administration, LVN 3 indicated she would document that at the end of the shift. b. On 11/12/19 12:10 PM at the nursing station during a review of the narcotic count binder with LVN 3 and the assistant director of nursing (ADON), the first page inside the binder was a form titled "Controlled Drugs Inventory". ADON stated the form was for the nurses to document the end of shift narcotic counts (at each shift change, the nurse coming on duty will do inventory count with the nurse going off duty, and they both would sign on the form after inventory was completed).	F 755	**MONITORING EFFECTIVENESS** The charge nurses will report any findings of medication cart binder log inaccuracies immediately to the DON for remedy/advice and instructions. The DON or clinical nurse consultant will conduct additional in-services when there is deemed a need for additional re-training of the nursing staff or policy revision. Policy effectiveness will be reviewed at the monthly and quarterly QA committee meeting as part of survey review for the next three months.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 755	Continued From page 52	F 755		

A review of the form indicated the areas for nurses to sign off the shift count that occurred at 7 am on 11/12/19, was left blank. LVN 3 indicated she did the count with the nurse going off duty, however, both did not sign the form.

A review of an undated facility's policy and procedure, titled, "Controlled Substances" indicated " ...Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must take the count together. They must document and report any discrepancies to the Director of Nursing ..."

c. On 11/12/19 at 9:32 AM during an inspection of the medication storage room with the assistant director of nursing (ADON), a review of the e-kit binders revealed there were two (2) pages of IV e-kit logs that was incomplete. The two pages combined contained the names of two residents and the quantity removed for 5 medications. However, the 2 pages did not contain information such as the date and time of the occurrences, the names of physicians, and nurses who had removed the medications.

On 11/12/19 at 9:32 AM during a review and interview, the medication disposition log binders indicated there were approximately 7 pages of medication disposition logs listing a total of 49 medications that did not contain the date of disposition. During a concurrent interview, ADON indicated the nurses had forgotten to fill out the forms completely.

A review of an undated facility's policy and procedure, titled, "Discarding and Destroying Medications", indicated the medication disposition

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 755	Continued From page 53 record will contain the following information: "the resident's name, date medication disposed, the name and strength of the medication, ..."	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756	**F756 – It is policy of this facility to develop and maintain policies for the monthly drug regimen review that includes timeframes for the different steps in the process the pharmacist must take when he/she identifies an irregularity that requires urgent action to protect the resident.** **CORRECTIVE ACTION** On 12/11/19, the clinical nurse consultant and pharmacy nurse consultant completed in-service training to licensed staff on the topic of drug regimen review with emphasis on the pharmacy monthly medication regimen review (MRR) for residents. On 12/05/19, the aDON reviewed the resident's MRR, dated 07/19/19, per physician no serotonin level indicated, to continue with the long-term medication. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** Any resident prescribed medication in the facility could have been affected by this deficiency with possible negative outcomes associated with the medication. On 11/14/19, the DON, aDON and medical records office reviewed other residents that are prescribed medication, plus reviewed corresponding pharmacy monthly regimen (MRR) documentation and found no other residents were similarly affected by this deficiency. **SYSTEMIC CHANGES**	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 756	Continued From page 54 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow up on a pharmacy monthly medication regimen 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) for one of 5 sampled residents (29), who was receiving antidepressant (for treatment of depression and other mental health conditions) medications. Resident 29, who was receiving Cymbalta and Fluoxetin while taking Tramadol. The attending physician failed to document in the resident's medical records the identified irregularity had been reviewed and what, if any, action was to be taken to address it. This deficient practice placed Resident 29 at risk for serotonin syndrome. (symptoms include high body temperature, agitation, increased reflexes, tremor, sweating, dilated pupils, and diarrhea occurs when taking medications that causes high levels of the chemical serotonin to accumulate in the body). Findings: A review of Resident 29's Admission Face Sheet	F 756	The medical records staff will complete random weekly audits of residents' assessments with focus on pharmacy MRR follow-through. Audit reports will be provided to the DON for accuracy review. **MONITORING EFFECTIVENESS** As part of survey review, this deficiency will be discussed at the monthly and quarterly QA committee meeting for any suggestions/advice from the facility's Medical Director, for the next three months. The charge nurses will continue to report any suspected medication side effects promptly to the DON and resident's primary physician for advice/instructions. The DON or clinical nurse consultant or pharmacy nurse consultant will conduct in-services when there is deemed a need for additional training of the nursing staff. Any continued findings of nursing staff noncompliance will be discussed at the monthly and quarterly QA meeting for possible policy revisions.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 756	Continued From page 55	F 756		

indicated the resident was admitted to the facility on 11/6/13 and readmitted on 8/16/19 with diagnoses including major depressive disorder (a condition of isolating self), chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), essential hypertension (high blood pressure with no known secondary cause), and difficulty in walking.

A review of Resident 29's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/23/19 indicated the resident had the ability to understand and be understood by others. Resident 29 had a brief interview of mental status (BIMS) score of 14 (score of 13-15 indicated intact cognitive skills for daily decision making). The MDS indicated Resident 29 required extensive assistance from staff with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS also indicated Resident 29 was on antidepressant medication.

A review of Resident 29's Physician Order dated 8/19/19 indicated an order for Cymbalta capsule delayed release 20 milligram (mg) by mouth Fluoxetine 20 mg by mouth, one time a day for depression, and Tramadol 25 mg by mouth for pain.

A review of Pharmacy Consultant MRR and recommendation dated 7/19/19 indicated the combination of Tramadol, Fluoxetine and Cymbalta for Resident 29 may lead to an increased risk for serotonin syndrome. The recommendations included to consider to change Tramadol to another analgesics, and the combination of Cymbalta with Fluoxetine increase

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 756	Continued From page 56 risks as well. A review of a document titled, "Note To Attending Physician/Prescriber" dated 9/2019, indicated pharmacy recommendation with combination of Tramadol, Fluoxetine and Cymbalta for Resident 29 may lead to an increased risk for serotonin syndrome in the resident. The recommendations indicated to consider changing Tramadol to another analgesics, and the combination of Cymbalta with Fluoxetine increase risk as well. A review of the physician "Progress Note" dated 9/26/19, indicated Resident 29 was on Tramadol, Fluoxetine and Cymbalta, which may lead to an increased risk for serotonin syndrome. The Pharmacy recommendations indicated to consider to change Tramadol to another analgesic (and the combination of Cymbalta with Fluoxetine increase risk as well) relayed to physician. The notes indicated "will consider to change." However, the physician had not considered to follow the Pharmacists recommendations. A review of Medication Administration Record (MAR) dated 7/19, 8/19, 9/19, 10/19, and 11/19, indicated Resident 29 had been receiving Tramadol, Cymbalta, and Fluoxetine, even after the pharmacy recommendations. On 11/13/19 at 12:32 PM, during record review and interview witnessed by Registered Nurse (RN 3) indicated pharmacy recommended an evaluation to be done for Resident 29 because of the use of two combined antidepressants on 7/19/19. RN 3 stated since then the physician had not evaluated the use of these two combinations. RN 3 stated it was up to the physician to decide	F 756		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 756	Continued From page 57	F 756		

when to order labs for resident on antidepressants. RN 3 stated nothing was done by the physician in regard to the pharmacy recommendations.

On 11/13/19 at 12:53 PM, during interview and record review witnessed by Director of Nursing (DON), pharmacy regimen was attempted first on 7/19/19, and Resident 29 was discharged home and readmitted on 8/16/19, since then resident had continued on Cymbalta and Fluoxetine 20 mg for depression manifested by feeling of sadness as a result of health condition. The DON confirmed another attempt was done on 9/25/19.

On 11/13/19 at 02:52 P.M., during an interview, Medical Doctor (MD1) stated she did not recall making any change. MD 1 stated "we are here everyday if we do see clinically that a resident requires a change that is when we make changes. I never order for serotonin levels. I look at my residents clinically before I order any lab. I did not follow up and did not know that I have to document if I don't follow up with the pharmacy recommendation. I should follow up with the pharmacy recommendation without any one reminding me. I do not need anyone to remind me. When pharmacist comes to the facility they do not see residents and assess them but, we do see residents and complete assessment if there is any clinically indicated symptom we make changes." MD 1 stated she did not order serotonin levels because the resident was not showing any symptoms of serotonin syndrome. However, MD 1 acknowledged not documenting the rational for not following the MRR review.

On 11/13/19 at 3:04 P.M., during interview, RN 2 stated it depended on a physician to monitor

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 756	Continued From page 58 resident's serotonin levels when a resident was taking antidepressant medication, but usually other physicians monitors the residents every quarter for side effect of medication and orders for serotonin level. A review of undated facility's policy and procedure titled, "Medication Regimen Reviews" indicated the goal of the Medication Regimen Review (MRR) is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758	**F758 – It is the policy of this facility to ensure any drug that affects brain activities associated with mental processes are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.** **CORRECTIVE ACTION** a. On 11/12/19, the DON corrected the psychoactive summary sheet for Resident-72. From 12/03/19 to 12/06/19, the DON completed in-services to licensed staff regarding importance of documenting all behavioral episodes in the eMAR and psychoactive summary to eliminate the potential of an unnecessary psychotropic medication affecting or not affecting the resident's condition. b. On 11/12/19, the DON updated the Resident-91's care plan to include non-pharmacological interventions.	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 758	Continued From page 59 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of 25 sampled residents (72, 91) did not recieve unnecessary medications by: Resident 72's psychoactive summary sheet data matched the behavioral episodes documented in the electronic medication administration record (eMAR). Resident 91 received non-pharmacological intervention prior to the use of Ativan (antianxiety) medication. These deficient practices had the potential of	F 758	From 12/03/19 to 12/06/19, the DON conducted in-services to licensed staff how to properly assess all residents for signs and symptoms related to anxiety disorder or inability to keep still and retraining nurses on providing non-pharmacological interventions; and follow-up with the physician for new orders, when necessary. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** a. All residents with orders for routine medication could have been affected by this deficiency, if there were side effects from medication, such as antipsychotics, due to inaccurate nurse documentation. After local department of health surveyor findings on 11/12/19 the DON, MDS and medical records staff reviewed resident charts containing routine medication orders with a focus on antipsychotics cross referencing proper nursing documentation of behavior episodes. No other residents were found similarly affected by this deficiency. b. It would be beneficial for all residents in the facility if non-pharmacological interventions were initiated and successful prior to any medication administration. After the local department of health surveyor findings on 11/12/19 the DON reviewed any other potential residents where non-pharmacological interventions could have been used prior. There were no other findings of similarly affected residents for this deficiency. **SYSTEMIC CHANGES** The DON will conduct quarterly in-services to licensed nurses regarding proper resident assessment, documentation and monitoring of residents' signs and symptoms of anxiety	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 758	Continued From page 60 unnecessary psychotropic medication that may or may not affect the resident's condition. Findings: a. A review of Resident 72's electronic medical record indicated the resident started to receive Risperdal (an antipsychotic medication to treat psychiatric conditions) 0.25 milligrams (mg) twice a day for restlessness on 2/25/19. On 6/4/19, Resident 72's Risperdal was changed to 0.25 mg every morning and 0.5 mg at bedtime for behavior control. On 9/23/19, the indication of use for the Risperdal medication orders were clarified to dementia with behavior disturbance manifested by episodes of sexual inappropriate behavior towards staff/peers. On 11/12/19 at 4:00 PM, during an interview and a concurrent review of Resident 72's the electronic medication administration record (eMAR) where nurses documented each behavior episode, the assistant director of nursing (ADON) acknowledged that in Resident 72's eMAR of 10/2019, there were 3 episodes of behavior documented for inappropriate behavior towards staff and 3 episodes of behavior towards peers during the morning shift. However, a review of Resident 72's psychoactive summary sheet (a form that record the total behavior episode count in each month) indicated no episode occurred during the morning shifts in 10/2019. b. A review of Resident 91's Physician Order dated 10/16/19 indicated an order of Lorazepam (antianxiety medication) 0.5 milligram (mg) every 6 hours related to anxiety disorder manifested by verbalization of feeling anxious.	F 758	disorder; reminding nurses of proper medication administration at all times, and possible non-pharmacological interventions and reminding nurses to record any resident change of condition (COC) or behavioral episode with accurate documentation and follow-up with the DON and resident's physician to ensure the proper plan of care is implemented. Review of non-pharmacological interventions, whenever possible, may also be discussed during scheduled quarterly IDT care plan meetings with residents and/or families. **MONITORING EFFECTIVENESS** The DON or clinical nurse consultant will conduct quarterly in-services to MDS staff discussing accurate documentation of behavioral episodes as well as emphasis on accurate assessment of residents for possible non-pharmacological interventions reminding nurses to contact the physician, if clarification is needed. This policy will be remaining in effect for the next six months. Resident care plans may be reviewed at the quarterly IDT meeting to ensure a comprehensive care plan is reflective of the resident's needs and interests. The clinical nurse consultant will conduct random resident chart audits on a quarterly basis to ensure compliance with facility policies and regulations. Audit results will be reported to the DON and Administrator for review. Findings will be addressed by the DON and discussed in the monthly and quarterly Quality QA committee meeting as part of survey review.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 758	Continued From page 61 A review of the November 2019 physician order for Resident 91 indicated an order of Ativan 0.25 mg every 6 hours as needed for anxiety disorder manifested by verbalization of anxiousness. A review of the medication administration record (MAR) indicated that Resident 91 had been monitored for anxiety manifested by verbalization of feeling anxious. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 10/9/19 for Resident 91 had a brief interview of mental status (BIMS screens for cognitive impairment) a score of 15 (a score of 13-15 indicates intact cognition), with diagnoses that included anxiety disorder (are a group of mental disorders characterized by significant feelings of anxiety and fear, a worry about future events, and fear is a reaction to current events), depression (a feeling of sadness, misery, unhappiness, sorrow, gloom, gloominess, dejection, downheartedness, low spirits, heavy-heartedness, discouragement, despair, desolation, hopelessness), bipolar disorder (a mental condition marked by alternating periods of elation and depression), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide to reach the heart, brain, or the rest of the body that can cause symptoms such as shortness of breath). A review of Resident 91's care plan indicated the resident used anti-anxiety medication (Ativan) related to anxiety disorder manifested by	F 758		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 758	Continued From page 62 repetitive physical movement of the arms. On 11/12/19 at 2:57 p.m., during an interview, Licensed Vocational Nurse 8 (LVN) stated the "Signs of anxiety are hyperventilation, high pulse rate, shortness of breath, respiratory distress. As far as behavior, they couldn't stay still, cannot calm down. When the resident verbalized "I'm anxious", as a nurse I will do my assessment. In writing orders for example, the name of medicine, strength, frequency, route, stop date, diagnosis and specific manifestations should be there". On 11/12/19 at 3:50 p.m., during an interview and concurrent record review, the Director of Nursing (DON) stated the signs and symptoms of anxiety includes fidgeting. Prior to pharmacological interventions, we should do the non-pharmacological interventions first and determine what is the cause and it should reflect in the care plan. Resident 91's care plan did not indicate that a non-pharmacological interventions were to be provided prior to medications." A review of an undated facility's policy titled, "Behavioral Assessment, Intervention and Monitoring", indicated that interventions will be individualized. When medications are prescribed for behavioral symptoms, documentation will include rationale for use, other approaches and interventions tried prior to the use of medication, specific target behaviors and expected outcomes.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761	**F761 – It is the policy of this facility to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and the expiration date when applicable.**	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 761	Continued From page 63 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a box labeled "Bedhold" would contain medications for residents currently on bedhold (when a nursing home holds a bed for the resident when they go into the hospital). Five (5) out of 11 medications found in the Bedhold box had been discontinued and the rest were still active. This deficient practice had a potential for medication errors. Findings: On 11/12/19 at 9:40 AM during an inspection of	F 761	**CORRECTIVE ACTION** On 11/12/19, upon discovery, the identified box labeled 'Bedhold' was removed from the medication storage room and all discontinued medication was discarded appropriately based on facility policy. On 11/12/19, the DON gave a 1:1 counseling to the assistant DON (aDON) reminding properly label discard expired medication when applicable. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents with orders for routine medication could have been affected by this deficiency, if there were mislabeled or expired medications given to the residents by mistake. After discovery by the local department of health surveyor, the aDON checked all medication carts and biologicals storage areas and found no other deficient items. No other residents were found affected by this deficiency. **SYSTEMIC CHANGES** To prevent recurrence of this deficiency, the DON or department heads will complete frequent hallway rounds, focusing on biological storage areas and the medication storage room ensuring all internally stored items are properly labeled or discarded when applicable. **MONITORING EFFECTIVENESS** The charge nurse or nurse supervisor will correct any findings of policy noncompliance immediately with report discussed to the DON and central supply personnel. Any continued trends seen from this monitoring will be discussed at the daily	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 761	Continued From page 64 the medication storage room with the assistant director of nursing (ADON), there were 3 cardboard boxes sitting on the top shelf. ADON stated those boxes were for meds waiting to be disposed. Each box had a label adhered to the outside: Discard, SubAcute, and Bedhold. However, a closer look revealed those labels of the boxes had "X" marked over the words, "Discard" and "Bedhold". Inside the Bedhold box, there were 11 medications inside. During a concurrent interview, ADON indicated at least one of the residents, Resident 83 whom those medications belonged to were on bedhold but had since returned to the facility. On 11/12/19 at 10:01 AM during an interview, ADON stated Resident 83 was discharged on 11/9/19 and returned to facility on 11/11/19. A review of Resident 83's electronic medical record indicated resident had an order of bedhold for 7 days on 11/9/19 . On 11/12/19 at 10:23 AM upon reviewing those 11 medications, ADON stated 5 out of those 11 had been discontinued and the other 6 were still active medication for a current resident.	F 761	department head stand up meeting, plus monthly and quarterly during the QA committee meeting as part of survey review for advice or suggestions.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812	**F812 – It is the policy of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.** **CORRECTIVE ACTION** Immediately after observation by the local department of health surveyor on 11/07/19, the dietary supervisor removed the (2) 108-ounce cans of sweet potatoes from the kitchen for return to supplier for a refund. There was no affect on the daily food menus prepped for the residents. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** Food borne illnesses from contaminated food could have affected residents, staff and visitors in the facility.	11/21/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 812	Continued From page 65 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safe storage of canned food items, by failing to separate the dented cans them from non dented cans. This deficient practice had the potential for the kitchen staff to serve the residents with dent cans food which placed the residents at risk for food borne illness. Findings: During a kitchen tour on 11/07/19 at 11:02 a.m., with the Dietary Supervisor (DS 1), two 108 ounce (oz, unit of weight) cans of cut sweet potatoes were observed on the shelf with other canned items used for residents' meal consumption. Both cans had dents on the lower part of the cans. During an interview with the DS 1 on 11/14/19 at 12:07 p.m., she stated dented cans have to be separated from the other canned items. The DS 1 stated the risk of using the food in dented cans for consumption included contamination and	F 812	The facility Registered Dietitian (RD) conducted an in-service on 11/21/19 to kitchen staff emphasizing proper food storage procedure to prevent contamination or food borne illnesses from occurring. No incidents or symptoms of food borne illnesses were reported by nursing staff. No residents were noted affected by this deficiency. **SYSTEMIC CHANGES** The dietary supervisor or her designee on weekends will monitor the kitchen supply stock daily to ensure that any canned goods are free from dents and stored properly. Any canned goods that are opened will be labeled and dated accurately. Any stock that is found during the daily audit to be dented will be discarded and returned for a refund. **MONITORING EFFECTIVENESS** For this deficiency, the RD will continue to make monthly kitchen department audits to ensure continued compliance with food storage policy and procedures and provide additional in-services, if needed. This policy will be in place permanently. Any findings from visits will be reported to the Administrator and to the facility QA nurse consultant, as well as discussed in the monthly and quarterly QA meeting for suggestions or policy updates.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 812	Continued From page 66 botulism (poisoning caused by the bacterium Clostridium Botulinum (C. botulinum produces spores that can survive in poorly preserved or canned foods. When consumed, even minimal amounts of the toxin can cause severe poisoning). A review of a facility's policy revised on 2018 titled, "Dented Cans" indicated food in unlabeled, rusty, leaking, broken containers or cans with side dents, rim dents or swells shall not be retained in the facility. All dented cans and rusty cans shall be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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(i) Medical records. §483.70(i)(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	F 842	**F842 – It is the policy of the facility to ensure all communications between the social services department and family representatives is documented in the resident's clinical records accurately.** **CORRECTIVE ACTION** Resident-20 was discharged from the facility on 11/13/19 and has not returned. On 12/09/19, the Administrator completed a 1:1 training with the social services designee (SSD) regarding resident routine ancillary services follow-up with emphasis on accurate social services documentation in the resident's clinical records to ensure routine ancillary services are not missed. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The SSD and medical records staff reviewed other residents that received or scheduled to be visited by an ancillary service. No other residents	12/09/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 842	Continued From page 67 §483.70(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(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(i)(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	F 842	were found similarly affected by this deficiency. **SYSTEMIC CHANGES** To prevent recurrence of the same deficient practice the social services staff will conduct monthly audits of residents that have a change-of-condition transfer to general acute hospital, with a return, to ensure all ancillary service documentation is compliant with facility policy. The social services staff will maintain a record of residents who receive ancillary services in the facility. **MONITORING EFFECTIVENESS** During the daily department head stand up meeting the SSD will report any incidents of missed ancillary services for suggestions/advise. As part of survey review, this deficiency will be discussed during the monthly and quarterly QA committee meeting for policy suggestions and advice.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 842	Continued From page 68 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 observation, interview and record review, the facility failed to ensure communication between social services and the family representative was documented in the resident's clinical records for one of 1 sampled resident (20), who required vision services. This deficient practice placed Resident 20 at risk for not receiving vision services in a timely manner and feelings of frustration by the resident's representative. Findings: During an observation on 11/13/19 at 2:05 p.m., Resident 20 was observed with eyes closed and was unable to respond to verbal questions. A review of Resident 20's admission records indicated the resident was admitted to the facility on 7/24/19 and re-admitted on 11/1/19 with diagnoses including but not limited to sepsis (the body's extreme response to an infection), acute hepatic failure (damaged liver), alcoholic cirrhosis (a late stage of injury or damage of the liver tissues) of the liver and hypokalemia (low potassium). During an interview with family member 1 (FM 1) on 11/13/19 at 2:16 p.m., FM 1 stated Resident 20 had been waiting for 3 months to see an eye specialist but "no one has shown up". FM 1	F 842		

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 842	Continued From page 69	F 842		

stated the resident was unable to read because she was unable to see clearly. FM 1 stated the issue was communicated with the facility social services director.

A review of Resident 20's Minimum Data Set ((MDS, a standardized comprehensive assessment and care screening tool) dated 8/18/19 indicated adequate ability to see fine details such as regular print in newspapers and books. There were no corrective lenses assessed. The resident had severe cognitive impairment (inability to think, understand and make daily decisions).

During an interview and concurrent record review with Minimum Data Set Nurse 1 (MDSN 1) on 11/13/19 at 2:52 p.m., the social services dated 8/16/19 indicated the resident had no glasses. There was no consultation for vision services in the medical record.

During an interview on 11/13/19 at 3:54 p.m., the Social Services Director (SSD) stated providers for ancillary services make routine visits. The SSD stated FM 1 had requested for vision consult for Resident 20. The SSD stated the consult was scheduled but the resident went out to the acute care hospital and needed to be re-scheduled. The SSD stated she would chart any communication with the family in the progress notes in the electronic health record (eHR). A review of the eHR indicated no progress notes indicating communication with the resident's family. The SSD stated she did not document her communications.

A review of the facility's policy titled, "Social Services Job Description" indicated the

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 842	Continued From page 70 administrative functions included social services charting including MDS, psychosocial evaluations, social histories, assessments, quarterlies, updates as need and Patient Care Plan entries to meet federal and state licensing requirements, facility policy and procedures and to accurately reflect resident needs.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	**F880 – It is the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.** **CORRECTIVE ACTION** From 12/03/19 to 12/06/19, the DON completed an in-service to licensed nurses regarding topics of infection control and prevention with discussion on medical device parts used internally on residents should be free from other contaminants and not come in contact with the floor. The DON and subacute RN supervisor reassessed Resident-20 and found no signs or symptoms of infection resulting from the recent wound VAC usage. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents that utilize medical devices that come in contact with internal body parts could have been affected by this deficient practice by creating a possible environment of disease and infection. After the local department of heath surveyor's findings, the DSD and subacute RN supervisor	12/12/19

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 880	Continued From page 71 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of one	F 880	checked all medical device tubing and randomly monitored staff during routine patient care to ensure staff adhered to the facility's proper infection control/prevention policy. No other residents were seen similarly affected by this deficiency. **SYSTEMIC CHANGES** The DSD will conduct quarterly in-services to staff on the subject of infection control, reminding them of the facility's policy for proper medical device usage/maintenance to prevent the spread or transmission of diseases and infections among residents, staff and visitors. This policy will be remaining in effect for the year. **MONITORING EFFECTIVENESS** The DON or DSD will conduct a skill competency check on all staff upon orientation, randomly thereafter and at annual evaluations to ensure compliance with the facility's infection control/prevention policy. This policy will be in place permanently. Any findings of staff failing to follow infection control preventive measures will be corrected immediately by the DSD for re-training and reported at the monthly QA meeting. Any trends seen regarding infection control improvements will be discussed at the quarterly QA meeting for suggestions.	

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 880	Continued From page 72	F 880		

sampled resident (Resident 20), who had a wound VAC (Vacuum assisted closure of a wound is a type of therapy to help wounds heal. It is also known as wound VAC) was free of possible contamination, by failing to keep the VAC tubing off the floor.

This deficient practice placed the resident at risk for infection.

Findings:

During a tour of the facility on 11/07/19 at 1:24 p.m., Resident 20 was observed lying on the right side and was unable to respond verbally to questions. A wound VAC tubing contained scant serosanguinous drainage was observed with the tubing on the floor, on the left side of the bed.

A review of Resident 20's admission records indicated the resident was admitted to the facility on 7/24/19 and re-admitted on 11/1/19 with diagnoses including but not limited to sepsis (the body's extreme response to an infection), acute hepatic failure (damaged liver), alcoholic cirrhosis (a late stage of injury or damage of the liver tissues) of the liver and hypokalemia (low potassium).

A review of Resident 20's Minimum Data Set ((MDS, a standardized comprehensive assessment and care screening tool) dated 8/18/19 indicated the resident was at risk of developing pressure ulcers. The resident had severe cognitive impairment (ability to think,understand and make daily decisions).

During a wound care observation with Licensed Vocational Nurse 4 (LVN 4) on 11/13/19 at 2:05

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 _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5648 EAST GOTHAM STREET BELL GARDENS, CA 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
F 880	Continued From page 73 p.m., Resident 20 was observed to have two stage 4 pressure ulcer sites, one on the left sacrum and another on the left buttocks. The pressure ulcer sites were draining scant serosanguinous (yellowish with small amounts of blood) fluid. During an interview on 11/13/19 at 2:33 p.m., LVN 4 stated Resident 20 had a wound VAC, but it was discontinued. A review of the physician order indicated to discontinue wound VAC on 11/12/19. During an interview with the Director of Nursing (DON) on 11/14/19 at 12:06 p.m., regarding the tubing of VAC was on the floor on 11/7/19, he stated no device part used internally on a resident should be touching the floor. The DON stated because a wound VAC is connected to a high risk for infection area of the resident's pressure ulcer, the tubing should no be touching the floor to avoid contamination. A review of the facility's policies provided during survey did not contain any guidance to keeping wound VAC or similar devices free from contamination.	F 880		