amended accepted 9/17/21 34180

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

PRINTED: 08/23/2021
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 _____	C 08/23/2021

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 of a Complaint investigation during an Abbreviated Standard Survey. Complaint number: CA00741501 Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 34180 The inspection was limited to the specific Complaint investigation and does not represent the findings of a full inspection of the facility. One deficiency was issued for CA00741501	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 9/10/21. 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 684 SS=G	Quality of Care CFR(s): 483.25 § 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 interview and record review, the facility failed to closely monitor and provide the necessary care and services for one of two sampled residents (Resident 1), after there was a change of condition ([COC] a sudden clinically	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 On 7/29/21, after local department of health surveyor findings, nursing staff followed up with resident's physician. Received new order from MD to monitor BP and pulse rate q8h x30days. Orders noted and carried out. Responsible family was informed/updated. AMENDED:	9/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Pellicer | TITLE: Administrator | (X6) DATE: 9/15/21

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.

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F 684	Continued From page 1 deviation from a resident's baseline in physical, cognitive [thought process], behavioral, or functional domains) that required close monitoring after it was reported to the physician. Resident 1 had a syncopal episode (fainting) reported to the physician without continued close monitoring for over three hours which lead to Resident 1's condition worsening and Resident 1 becoming hypotensive (a low blood pressure) with an altered level of consciousness ([ALOC] not as awake, alert, and reactive), difficulty breathing and diaphoresis (increased sweating). Resident 1's family member (FM 1) observed Resident 1 unarousable (unable to waken) and gasping for air and requested for the staff to call 911 (an emergency service) immediately. This deficient practice of the facility not closely monitoring Resident 1 after an initial COC resulted in a delay in diagnosis and care and services for Resident 1. Resident 1 required a transfer to the general acute care hospital (GACH) after the resident became unresponsive (not verbally responding) and unarousable on 6/19/2021 by emergency transport services (911). Resident 1 was bag to mask ventilated (a hand-held resuscitating [bring back to life] bag that delivers forceful air through the nose and mouth during an emergency) and diagnosed with septic shock (an infection that spreads throughout the blood and tissues, caused by extremely low blood pressure and can result in organ failure), severe sepsis (infection in the blood) and respiratory failure and acute kidney failure ([AKI] sudden episode of kidney failure or kidney damage), requiring intubation (tube insertion in the windpipe as a life saving measure when a person is not breathing independently) and ventilator (a machine that helps you breathe	F 684	On 8/24/21, licensed vocational nurse (LVN-2) was given a one-on-one in-service by the Director of Nursing (DON) regarding change-of-condition (COC) identifiers, follow through monitoring with facility's policy on acute condition changes. On 8/26/21, licensed vocational nurse (LVN-3) was given a one-on-one in-service by the DON regarding change-of-condition (COC) identifiers, follow through monitoring with facility's policy on acute condition changes. COC/SBAR skills check for licensed nurses was commenced on 8/24/21 through 9/2/21 by the DON with planned completion date 9/10/21. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents were at risk of being affected by this deficiency. On 7/29/21 and 9/2/21 medical records staff reviewed/searched for hypotension COC for other residents. No other residents were found similarly affected by this deficiency. From 8/24/21 to 8/27/21 in-services for licensed staff were done by the DON, regarding change-of-condition (COC) identifiers, the e-Interact reference tool, reminding them for signs and symptoms of hypotension and ensuring proper resident care is administered, with notification/updates made to the primary physician for any new orders, as needed; with facility's policy on Acute condition changes.	

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F 684	Continued From page 2 or breathes for you), required emergency hemodialysis (a medical procedure that clean blood for individuals with loss of normal kidney function). Resident 1 required hospitalized in the intensive care unit for 10 days. Findings: During a review of Resident 1's Admission Record (face sheet), the face sheet indicated Resident 1 was initially admitted to the facility on 8/7/2020 and last re-admitted on 7/6/2021. Resident 1's diagnoses included acute respiratory distress syndrome (difficulty breathing when not enough air is moving around in the body) and oxygen cannot get into the body), hypertension ([HTN]-high blood pressure), heart failure (the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), and a lack of coordination (inability to maintain balance). During a review of Resident 1's Minimum Data Set (MDS) a standardized assessment tool and care screening tool, dated 5/14/2021, the MDS indicated Resident 1's cognition (thought process) was severely impaired, required extensive assistance with one-person physical assist with bed mobility, toileting and personal hygiene and a two-person assistance with a two-person assistance with transfers. During a review of Resident 1's revised care plan, dated 8/8/2020 and titled "Potential for cardiovascular (heart) distress related to hypertension and CHF," the staffs' interventions included to give medications as ordered, monitor for side effects such as orthostatic hypotension (a drop in the blood pressure measurement while lying flat or standing) and increased heart rate, obtain blood pressure readings (measurement)	F 684	On 8/24/21, 8/30/21 in-service reminders were done for certified nursing assistants (CNAs) by the DSD office, regarding monitoring their residents for any change-of-condition (COC), prompt reporting to the charge nurse or supervisor or department heads of any resident changes. **SYSTEMIC CHANGES** To prevent reoccurrence of this deficiency, the medical records office will report during department head stand-up meeting resident COCs noted in nursing communication log, as well as conduct daily audits of residents with a COC, providing those audit results to the charge nurse communication binder located in the nurse's station and report to the DON for his review to ensure follow-up, accurate documentation and care is provided. The DSD office will conduct quarterly and as needed in-services to licensed nurses and CNAs reminding of proper assessment, documentation, reporting tasks, monitoring for resident's COCs and following physician orders on additional monitoring instructions or interventions to ensure proper plan of care is implemented. This policy will be remaining in effect for the year. During daily rounds, CNAs and charge nurses will monitor residents for any signs and symptoms denoting a COC, reporting any findings to the DON or RN supervisor and logging/communicating for the change-of-shift huddle endorsement.	

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F 684	Continued From page 3 per physician order. During a review of Resident 1's recapitulated (a summary) physician's orders, dated 6/2021, the orders indicated to the following: 1. Staff to monitor blood pressure once daily every Thursday. 2. Staff to monitor oxygen saturation ([O2] amount of oxygen in the blood) every shift. 3. Staff to monitor body temperature every shift and call the physician if the temperature is greater than or equal to 100 degrees Fahrenheit (F), (Normal Reference Rate ([NRR]= 97.0-99.0 F). During a review of Resident 1's COC note, dated 6/19/2021 and timed at 12:30 p.m., the COC note indicated during lunch, Resident 1 was observed as being weak, cold, and clammy (sweaty), while sitting in his wheelchair in the middle of the room. The COC note did not indicate if the staff assisted Resident 1 back to bed and elevated the head of the resident's bed. The COC indicated Resident 1 eyes were opened and was able to nod his head indicating yes and no. The COC indicated Resident 1's vital signs (V/S) were as follow: a blood pressure (BP) of 91/56 millimeters of mercury (mmHg [NRR = 90/60- 139/79 mm/hg]), pulse of 80 beats per minute ([bpm] NRR= 60-100 bpm), an oxygen saturation ([O2] oxygen in the blood) of 92 percent ([%] NRR 95-100%). The COC indicated Resident 1's physician was notified at 12:35 p.m. and the staff received orders to administer two to three (2-3) liters ([L] units of measurement) of continuous O2 to Resident 1. During a review of Resident 1's nurse's progress note (NPN), dated 6/19/2021 and timed at 2:15 p.m., the NPN indicated Resident 1 was alert,	F 684	**MONITORING EFFECTIVENESS** The 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. Resident care plans will be reviewed at their scheduled quarterly IDT meetings to ensure a comprehensive care plan is reflective of the resident's needs and interests. At the daily department head stand-up meetings, medical records staff will report the nurse communication summary log which includes any recent noted resident COCs. Policy and plan of correction effectiveness will be addressed and discussed by the DON or Administrator at the monthly and quarterly QA meeting for suggestions or policy revision as part of survey review.	

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F 684	Continued From page 4 responsive to verbal and physical stimuli (awakened by someone or something), had an O2 saturation of 92 % while on 2L of oxygen per minute, was oriented x 2, and had a blood sugar level of 85 mg/dL. The NPN indicated visual checks were rendered to Resident 1. During a review of Resident 1's clinical records, there was no documented evidence of frequent visual monitoring conducted by the staff. During a review of Resident 1's NPN, dated 6/19/2021 and timed at 3:30 p.m., the NPN indicated Resident 1 was verbally responsive, easily awaken to verbal and physical stimuli and had an O2 saturation of 90% to 92% while on 2L of oxygen per minute. The NPN indicated the staff would continue to monitor for any changes. During a review of the COC note, dated 6/19/2021 and timed at 6 p.m., the COC indicated, Resident 1 had an altered mental status ([AMS] any measure of arousal other than normal), was lying in bed with his eyes closed and unable to follow commands. The COC indicated Resident 1, had shortness of breath with a respiration rate (RR) of 18 bpm (NRR is 12-16 breaths per min), was sleepy and lethargic and V/S were as follow: an O2 desaturation of 83% while on 2L of oxygen per minute via NC, was hypotensive with a B/P of 88/56 mmHg, had an irregular pulse of 135 BPM, a body temperature of 98.3F. The COC indicated Resident 1 was placed on a non-rebreather (NRB) mask and was given 15 L of O2. The COC indicated Resident 1's physician was notified, and Resident 1 was transported to the GACH the paramedics (medical emergency trained personnel) for an evaluation.	F 684		

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F 684	Continued From page 5 During a review of Resident 1's Paramedic Run Sheet (PRS), dated 6/19/202 indicated the paramedics arrived at the facility on 6/19/2021 at 6:04 p.m., Resident 1 had an ALOC, diaphoretic, had shortness of breath with the use of his accessory muscles breathing (noticeable neck, chest and stomach muscles used when having difficulty breathing), was unconscious with a Glasgow Coma Scale ([GSC] an assessment used to determine level of consciousness [alertness/function]) of 6. According to the GCS, a score of 15 was normal and a score between 3-8 was indicative of severe decreased brain function and/or comatose. The PRS indicated Resident 1 was tachycardic (heart rate greater than 100 bpm) with a heart rate of 111 bpm, was tachypneic (respiration rate greater than 20 bpm) with a RR of 56 BPM, and an O2 saturation of 92%. The PRC indicated Resident 1 required a bag to mask ventilations was transported to the GACH. During a review of Resident 1's GACH face sheet, the face sheet indicated Resident 1 arrived to the Emergency Department (ED) on 6/19/2021 at 6:37 p.m. During a review of Resident 1's GACH ED H/P, dated 6/19/2021 and timed at 8:46 p.m., the H/P indicated Resident 1 arrived to the ED with altered mental status, severe sepsis (an infection in the blood), and respiratory failure. According to the GACH H/P, Resident 1's mental status had worsened throughout the day while at the skilled nursing facility (SNF) with an increased effort to of breathing. The H/P indicated when the family arrived at the facility, the family indicated Resident 1 was "not himself" and was breathing faster than usual and the family requested for the	F 684		

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F 684	Continued From page 6 paramedics to be called. According to the H/P when the paramedics arrived to the SNF, Resident 1's O2 saturations was in the 80's, was tachypneic with his eyes open and was not responding to verbal or noxious (physically harmful) stimuli. The H/P indicated Resident 1 was being bagged by the paramedics upon his arrival to the ED. The H/P indicated Resident 1 had a B/P of 86/58, a RR of 46 bpm, a HR of 107 bpm and an elevated white blood count (WBC) of 17.48 per microliter (uL) (NRR =levels 4.00 -11.00). According to the H/P, Resident 1 received Cefepime (medication used to treat an infection) 2,000 mg per intravenously ([IV] into the vein), vancomycin (medication used to treat an infection) 1,500 mg, norepinephrine (medication used to increase to control the blood pressure) 1 microgram ([mcg] a unit of measurement) and sodium chloride (salt water) 0.9% continuous IV fluids. According to the H/P Resident 1 was intubated (tube insertion in the windpipe as a life saving measure when a person is not breathing independently) and on a ventilator (a machine that helps you breathe or breathes for you) for six days and received emergency hemodialysis (a medical procedure that clean blood for individuals with loss of normal kidney function) treatment. The H/P indicated Resident 1's diagnoses included, septic shock (an infection that spreads throughout the blood and tissues, caused by extremely low blood pressure and can result in organ failure), severe sepsis (infection in the blood) and respiratory failure and acute kidney failure ([AKI] sudden episode of kidney failure or kidney damage). The H/P indicated Resident 1 was hospitalized in the intensive care unit for 10 days. During a telephone interview on 7/5/2021 at 3:09	F 684		

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F 684	Continued From page 7 p.m., Family Member 1 (FM 1) stated on 6/19/2021, it was reported to her on the same day Resident 1 was dizzy and had his B/P was low. FM 1 stated she called the facility and spoke to Licensed Vocational Nurse (LVN 3). According to FM 1, LVN 3 stated she did not recheck Resident 1's B/P because the Resident 1 was combative, would not eat his meal and she had to feed Resident 1. According to FM 1, on the same day Resident 1's family members at the facility when the family knew Resident 1 required immediate attention because he was not responsive and was slumped over in his wheelchair. During an interview on 7/29/2021 at 1:05 p.m., LVN 1 stated during a patient's change in their condition (COC), she would assess the resident, obtain the V/S and call the physician. LVN 1 stated she would then recheck the resident's V/S 10 minutes after the initial COC, then monitor the resident's vital signs every 30 minutes. During a concurrent interview and record review of Resident 1's COC note and NPNs on 7/29/2021 at 1:32 p.m., LVN 2 stated on 6/19/2021 after 10 a.m., Resident 1 was observed by a CNA slumped over to the left side while sitting in his wheelchair. LVN 2 stated Resident 1 was cold, his B/P was 91/56 and not responsive. LVN 2 stated she and the CNA transferred Resident 1 to the bed when he slowly started to respond. LVN 2 stated she placed Resident 1 on 5L of O2 and his O2 saturation was 92 %. LVN 2 stated Resident 1's physician was notified and received orders on Resident 1. LVN 2 stated she rechecked Resident 1's V/S every 30 minutes and the Resident 1's V/S was the same, the SBP (systolic [(top number] B/P) remained in the 90's. LVN 2 was asked if she documented	F 684		

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F 684	Continued From page 8 Resident 1's V/S after being checked every 30 minutes, LVN 2 stated she did not document Resident 1's follow-up V/S. During a concurrent interview and review of Resident 1's COC note and NPNs on 7/29/2021 at 3:08 p.m., LVN 3 stated on 6/19/2021 at 3 p.m., she received verbal report from the LVN from the prior shift that Resident 1 had episodes on hypoglycemia (low blood sugar) and required monitoring. LVN 3 stated she assessed Resident 1 and Resident 1 was awake, alert. LVN 3 stated Resident 1's V/S were normal with a SBP of 130 mm/Hg, a blood sugar level of 92 mg/dL and LVN 3 stated she did not document Resident 1's B/P or his blood sugar level. LVN 3 stated after she assessed Resident 1, she began passing medications to her assigned residents. LVN 3 stated on that same day between 4 p.m.to 5 p.m., she received a call from Resident 1's FM 1. LVN 3 stated when FM 1 asked about Resident 1's B/P, LVN 3 stated that was when she saw Resident 1's documented low B/P. LVN 3 stated she informed FM 1 that Resident 1's B/P was normal and had to feed Resident 1 because his blood sugar was in the 70's, he was weak, sleepy, arousable, and he could not feed himself. LVN 3 stated she monitored Resident 1 and did not document the resident's V/S or blood sugar readings. LVN 3 stated approximately 1 to 2 hours after Resident 1's assessment, she continued with her medication pass when she observed Resident 1's family at the door. LVN 2 stated she escorted Resident 1's family to his bedside, when Resident 1 was short of breath, was gasping for air, unarousable (not awake, not aware or responding) and five minutes later the family requested for Resident 1 to be transported to the hospital. LVN 3 stated the Registered	F 684		

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F 684	Continued From page 9 Nurse Supervisor (RNS) arrived at Resident 1's room, checked the resident B/P and Resident 1's B/P was low. LVN 3 stated Resident 3 had a O2 saturation level of 82% while receiving 15L of O2. LVN 3 stated the paramedics arrived and transported Resident 1 to the hospital. During an interview on 7/29/2021 at 3:40 p.m., RNS stated on 6/19/2021, she was on the sub-acute (24-hour inpatient care and recovery for those with a serious illness, injury or disease or health problems) unit when she heard overhead page of a "code blue (facility staff alert to indicate a medical emergency, such as cardiac or respiratory arrest and the staff should respond) to ensure the staff was completely prepared before they are faced with a real situations)." RNS stated when she arrived at Resident 1's room, Resident 1 was unresponsive, had an ALOC, had a low B/P and instructed the staff to call the paramedics. RNS stated residents with a SBP reading of 70-80's, 911 should be called and residents with a SBP reading of 90's the staff should monitor resident's B/P every 30 minutes and the B/P recordings should be documented in the resident's NPN. During a telephone interview on 8/3/2021 at 12:54 p.m. FM 2 stated on 6/19/2021, she and two other family members arrived at the facility. FM 2 stated when she saw Resident 1, she immediately knew something was wrong. FM 2 stated Resident 1 was totally different from his normal self, he was not talking or moving at all. FM 2 stated she asked the nursing staff to check Resident 1 because he had a strange look, his skin color was not normal and asked the nursing staff to call 911.	F 684		

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F 684	Continued From page 10 During a concurrent interview and record review of Resident 1's COC and NPNs, on 7/29/2021 at 3:56 p.m., the Director of Nursing (DON) was asked about the frequency of monitoring Resident 1's V/S during a COC, the DON stated the staff documented a follow-up note and he would conduct an in-service for the staff. The DON was asked would the staff conduct monitoring after a resident's COC if there was no policy and procedure (P/P), the DON did not respond. The DON stated he would conduct an in-service on monitoring residents during a COC. The DON was asked what the staff would refer to after he conducted an in-service if there was no facility P/P on monitoring, the DON stated he would conduct a staff in-service on monitoring based from the facility's current P/P. The DON was asked if Resident 1's B/P of 91/51 mm/Hg considered a COC, the DON stated, "No, but Resident 1 was back from the hospital and was doing fine." During a review of the facility's undated P/P titled, "Change in a Resident's Condition or Status," the P/P indicated for the nurse would notify the resident's attending physician or physician on call when there has been a (an) significant change in the resident's physical/mental condition, need to transfer the resident to a hospital/treatment center, specific instruction to notify the physician of changes in the resident's condition. The P/P indicated a "significant change" of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by the staff or by implementing standard disease related clinical interventions (is not "self-limiting"), impacts more than one area of the resident's health status. The P/P indicated the nurse would record in the resident's medical	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 _____	C 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCREST NURSING CENTER	5848 EAST GOTHAM STREET BELL GARDENS, CA 90201

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F 684	Continued From page 11 record information relative to changes in the resident's medical/mental condition or status.	F 684		