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 08/13/2024

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

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F 000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during the investigation of one complaint.

Complaint number: CA00913945.

The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

Two deficiencies were issued for complaint number CA00913945. See tags F552 and F657.

9/12/24

F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 552	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident 1,Consent was verified and updated on August 27, 2024. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** An audit was conducted on August 27-28, 2024 by the medical records director to identify residents who receive psychotropic medication. No negative finding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/30/24

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 552	Continued From page 1 failed to obtain an informed consent (process of communication between resident/responsible party and health care provider that often leads to agreement or permission for care, treatment, or services) prior to the administration of psychotropic medication (medications that affect the mind, emotions, and behavior) for one out of one sampled resident (Residents 1). 1. The facility did not ensure an informed consent was obtained when lorazepam (medication that relieves symptoms of anxiety, causes paranoid or suicidal ideation and impairs memory, judgment, and coordination) medication dosage was increased from 0.5 milligrams (mg, unit of measurement) to 1 mg for Resident 1. This deficient practice violated Resident 1 ' s right to make an informed decision prior to the administration of lorazepam medication. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on 5/4/2024 with diagnoses including anxiety disorder (an intense, excessive, and persistent worry and fear about everyday situations) and depression (a common and serious medical illness that negatively affects how a person feels, the way a person thinks and how they act. It causes feelings of sadness and/or a loss of interest in activities a person once enjoyed). During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/5/2024, the MDS indicated Resident 52 ' s cognitive skills (mental action or	F 552	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** On August 26-28, Director of Nursing/Designee inservice was conducted related to license staff obtaining consents for psychotropic medication to ensure the process for the following: • Ensuring that the facility will inform residents and/or resident's responsible party of the initiation, reason of use, and risk associated with the use of psychotropic medications • Medical records will audit 2 times a week for 2 weeks • Medical records will then be audit a week for 2 weeks The DON/ or designee will be responsible for ensuring the completion of the audit. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Facility will monitor and audit the psychotropic consents monthly for 3 months and report findings to the QA Committee for 3 months.	9/12/24

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F 552	Continued From page 2	F 552		

process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 required supervision for eating, toileting hygiene, personal hygiene, and shower/bathing self. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) for dressing and putting shoes on.

During a review of Resident 1 ' s History and Physical (H&P) dated 7/2/2024, H&P indicated Resident 1 had the capacity to understand and make decisions.

During a review of Resident 1 ' s Order Summary Report dated 7/13/2024, the Order Summary Report indicated Resident 1 was ordered to receive Lorazepam 1 milligram (mg) tablet every 12 hours as needed for anxiety.

During a review of Resident 1 ' s medical chart, the medical chart did not have an informed consent for the administration of lorazepam 1 mg medication.

During a concurrent interview and record review on 8/13/2024 at 2:49 p.m. with Licensed Vocational Nurse (LVN 1), Resident 1 ' s medical chart was reviewed. LVN 1 stated she did not find the informed consent for lorazepam 1 mg. LVN 1 stated a nurse must verify if there was an informed consent prior to the administration of an antipsychotic medication. LVN 1 stated every time there was a change in dosage for an antipsychotic medication, the licensed nurse must obtain an informed consent. LVN 1 stated Resident 1 received a medication that she did not consent to receive. LVN 1 stated it was important to get an informed consent to inform Resident 1

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F 552	Continued From page 3	F 552		

of new medication dosage and to get Resident 1 ' s consent to receive medication. LVN 1 stated the licensed nurses were liable of administering medication to Resident 1 without her being aware of the medication change and without her giving her consent.

During an interview on 8/13/2024 at 3:43 p.m. with LVN 2, LVN 2 stated a nurse must check if there was an informed consent before the administration of the antipsychotic medication. LVN 2 stated the inform consent was the acknowledgement that a resident was informed about the medication and the resident gave their consent to receive the medication. LVN 2 stated a new informed consent was needed when the dosage of an antipsychotic medication was increased or decreased. LVN 2 stated Resident 1 needed an informed consent for Lorazepam because it was a chemical restraint. LVN 2 stated lorazepam should have not been administered to Resident 1 because there was no informed consent for that medication.

During an interview on 8/13/2024 at 4:22 p.m. with Registered Nurse (RN 2), RN 2 stated when there was an increase on a medication a new informed consent was needed. RN 2 stated if a medication dosage was increased and there was no informed consent for the new dosage, the facility would not be in compliance and the medication should have not been administered to Resident 1. RN 2 stated it was important to have an informed consent for all staff to be on the same page with the care for Resident 1.

During a review of the facility ' s Policy and Procedure (P&P) titled "Resident Rights", dated 2/2021, the P&P indicated residents had the right

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F 552	Continued From page 4 to be informed of, and participate in, his or her care planning and treatment. During a review of the facility ' s P&P titled "Antipsychotic Medication Use", dated 7/2022, the P&P indicated all residents will be informed of the recommendation, risk, benefits, purpose and potential adverse consequences of antipsychotic use and residents may refuse medications of any kind.	F 552		9/12/24
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	**Corrective Actions taken for those residents alleged to have been affected by the deficient practice are:** Resident 1s plan of care was updated on August 27 for lorazepam. **Actions taken to identify other residents that may have the potential to be affected by the same deficient practice:** Care plans were reviewed for residents with psychotropic medications with no other concerns noted. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** On 8/26/24-8/28/24 DON /designee conducted the in-service the Licensed nurses and MDS staff regarding the development, update and implementation of the care plans.	

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F 657	Continued From page 5 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: During an interview and record review, the license nurses failed to review, update, and/or revise a care plan (written document developed for each individual by the support team using a person-centered approach that describes the supports, services, and resources provided or accessed to address the needs of the individual) to reflect the physician current order for lorazepam (medication that relieves symptoms of anxiety [feeling of unease, excessive worry]) for one out of one sampled resident (Resident 1). This deficient practice had the potential to result in Resident 1 not receiving an accurate dose of lorazepam and had the potential to negatively affect Resident 1 ' s physical and psychosocial well-being. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on 5/4/2024 with diagnoses including anxiety disorder (an intense, excessive, and persistent worry and fear about everyday situations) and depression (a common and serious medical illness that negatively affects how a person feels, the way a person thinks and how they act. It causes feelings of sadness and/or a loss of interest in activities a person once enjoyed). During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/5/2024, the MDS indicated	F 657	The medical department will audit weekly the care plan to ensure a care plan developed to address the resident's individual needs are complete. **How the facility plans to monitor its performance to make sure that solutions are sustained.** MDS/designee will monitor compliance through weekly review of care plans Findings will be reported to QA committee by MDS for further recommendations and follow up x 3 months.	9/12/24

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F 657	Continued From page 6	F 657		9/12/24

Resident 52 ' s cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 1 required supervision for eating, toileting hygiene, personal hygiene, and shower/bathing self. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) for dressing and putting shoes on.

During a review of Resident 1 ' s History and Physical (H&P) dated 7/2/2024, H&P indicated Resident 1 had the capacity to understand and make decisions.

During a review of Resident 1 ' s Order Summary Report dated 7/13/2024, the Order Summary Report indicated Resident 1 was ordered to receive Lorazepam 1 milligram (mg, unit of measurement) tablet every 12 hours as needed for anxiety.

During a review of Resident 1 ' s Care Plan for anti- anxiety medication related to anxiety disorder dated 5/6/2024, it indicated the goal was for Resident 1 to be free from discomfort or adverse reactions related to anti-anxiety therapy. The care plan indicated the interventions was to administer Lorazepam 0.5 mg tablet every 12 hours as needed for anxiety and to administer anti-anxiety medication as ordered by physician.

During an interview on 8/13/2024 at 3:21 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated when a medication dosage was increased or decreased, the care plan must be revised. LVN 2 stated care plans served as a plan of care for nurses to follow. LVN 2 stated if the care plan was not revised, nurses would not know of the

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F 657	Continued From page 7 new medication order. During an interview on 8/13/2024 at 4:22 p.m. with Registered Nurse (RN 2), RN 2 stated a care plan must be revised when the doctor increased or decreased a medication. RN 2 stated it was important to revise care plans to provide a continuous care to the residents. RN 2 stated when Lorazepam was increased from 0.5 mg to 1 mg, the licensed nurse should have revised the care plan to reflect the new doctor order. The RN 2 stated care plans must be revised because it is the plan of care that licensed nurses must follow to safely care for residents. RN 1 stated if a care plan was not revised when there was a new medication order, the licensed nurses would not administer the correct medication to the resident. During a review of the facility ' s Policy and procedure (P&P) titled "Care Plans, Comprehensive Person-Centered", dated 3/2022, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change.	F 657		9/12/24