

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

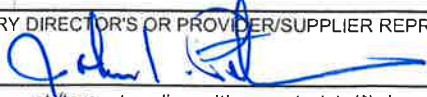
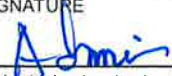
PRINTED: 04/14/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056220</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/13/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIARCREST NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5648 EAST GOTHAM STREET BELL GARDENS, CA 90201</b>
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F 000	INITIAL COMMENTS  The following reflects the findings of the California Department of Public Health during the investigation of a complaint or a Facility Reported Incident (FRI). Complaint Number: CA00774156 Representing the Department: Health Facilities Evaluator Nurse(s): 43906 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the complaint number: CA00774156 (Refer to Ftag 725).	F 000	"This Plan of Correction constitutes the Facility's credible allegation of compliance. Briarcrest Nursing Center, hereinafter referred to as BCNC, makes its best effort to operate in full compliance with both Federal and State laws. Nothing included in this Plan of Correction to comply with its regulatory obligation and does not waive any objections to the merits of form of any allegations contained herein. Please note that BCNC may contest the merits and/or form of any of the deficiency findings alleged below.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. 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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725	It is the policy of the facility to have sufficient nursing staff with 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 plan of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required.	5-23-22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <b>5/2/22</b>
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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 725	<p>Continued From page 1 limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide sufficient staffing to accommodate bed bound resident needs in repositioning or turning every 2 hours. This deficient practice resulted in residents not receiving needed direct patient care with potential for decline in skin integrity.</p> <p>Findings: During an unannounced visit at facility on 3/7/2022 at 8:44 am, call lights ( a device used by a resident to signal need for assistance) for rooms 121,119 and 115 was on with 2 Certified Nursing Assistant (CNA) and 1 Licensed Vocational Nurse (LVN) by the hallway and not answering call light. During an interview on 3/7/2022 at 9:55 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated that she works at the sub- acute unit, and she takes care of 9-10 total residents. CNA 1 stated that sometimes she was not able to finish her assignment or most of the time stayed overtime to finish task, CNA 1 admitted she could not reposition or turn dependent residents regularly due to heavy assignments and getting frustrated, and has told the Administrator and Director of Nursing (DON). CNA 1 further stated that she tries to give care to her residents as much as she can. CNA stated that she had back pain after work. During an interview on 3/7/2022 at 10:09 a.m. with Director of Staff Development (DSD), DSD</p>	F 725	<p><b>Corrective Action for Residents Found to have been affected by this Deficiency:</b></p> <p>On 5/1/22, the Social Service Director and the Social Service Assistant interviewed the residents assigned in rooms 121, 119 and 115 on 3/7/2022. 8:8 resident interviewed have no concern on call lights response.</p> <p><b>Identification of other Residents Having the potential to be affected by The same deficient practice and corrective action that will be taken:</b></p> <p>On 5/1/22 The facility Department Heads conducted an interview to all the resident for call light response using the facility developed monitoring tool (Angel Rounds), no resident was identified with concern on call light response.</p> <p><b>Measures/Corrective Action that will be Put into place to ensure that this Deficiency does not recur:</b></p> <p>On 5/1/22, the Director of Staff Development inserviced the licensed nurses and CNA on the facility's policy and Procedure on call light.</p>		

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F 725	Continued From page 2 stated that she was responsible for staffing for CNA's. While Director of Nurses is responsible for staffing Licensed Vocational Nurses, LVN's or charge nurses DSD stated that we both communicate how many staff needed on the floor on daily basis during stand-up meeting because census changes daily with admission and transfer. DSD stated that tried to meet the 2.45 Actual Direct care Services Hours Per Patient Day (DHPPD) required hours daily. During an interview on 3/7/2022 at 10:25 am with CNA2, CNA 2 stated that CNA are short most of the time, the problem is when somebody call in sick. CNA2 said it was brought up to the attention of DSD and Director of Nursing (DON). CNA2 said that sometimes it's difficult to turn or repositioned timely due to workload but CNA1 and CNA 2 stated that they try to help each other. During an interview on 3/7/2022 at 10:29 am with DON, DON stated that problem with staffing started during pandemic DON stated that he tries to hire more people but the offer money for other facilities is too high, and he cannot compete with the price, registry was used to fill up short of staffing, but it is also difficult to get nurses. DON said that care for residents is highly affected if the facility is short on nurses. DON also validated that on 2/19/2022, 2/21/2022, 2/26/2022 they are below the Final Nursing Hours Per Patient Day (NHPPD). During an interview and concurrent review on 3/7/2022 at 11:24 am with DSD and DON, DSD stated that ideal for 7-3 CNA should have 6-7 resident depending on acuity of resident. DSD said that it could affect patients care if facility is short staffed like call light will not be answered in a timely manner, Resident's need will not be met, and we cater for dementia care residents. DSD confirmed that one holiday they are short of	F 725	On 5/1/22, the Director of Staff Development inserviced the licensed nurses and CNA on the facility's policy and procedure on turning and repositioning including to accommodate bed bound resident with potential for decline in skin integrity in repositioning or turning every 2 hours.  <b>Measures that will be implemented to Ensure that solutions are sustained:</b>  The facility developed a monitoring tool (Angel Rounds) which include the resident's dignity is maintained such as the call light response. The facility Department Heads including the weekend MOD (Manager of the Day) are assigned their responsible room for this daily task and (or) for the completion of the Angel Rounds. The result (s) of the Angel Rounds are further discussed or reviewed during the Stand-Up meeting to identify trend and needed correction. The documented results will be forwarded to the QA & A Committee and will be discussed by the Social Service Director and (or) designee monthly X 3 month for further review and action planning or until the QA & A Committee determines compliance.		

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F 725	Continued From page 3 nursing hours and DSD is trying to hire more people and said that she tried to use registry to help in there staffing. During a record review of random nursing hours dated: a. 2/19/2022 total hours of NHPPD- 3.343 b. 2/21/202 total hours of NHPPD- 3.042 c. 3/5/2022 Scheduled NHPPD-3.16 d. 3/6/2022 actual NHPPD 2.78 A review of All Facilities Letter (AFL) dated 1/23/2018 indicated, effective July 1,2018, SB 97 ( Chapter 52, Statutes 2017) requires SNFs, except those that are a distinct part of general acute care or a state- owned hospital or development center, to provide a minimum of 3.5 direct care service hours per patient day, with a minimum of 2.4 performed by certified nurse assistants.	F 725	The facility continues with the advertisement of staff through Indeed.com and including having two registry company namely Medeley and Clipboard for its CNA daily staffing. The DSD and (or) designee will discuss the NHPPD during the daily stand-up meeting. The daily NHPPD results will be forwarded to the QA & A Committee and will be discussed by the Director of Staff Development and (or) designee monthly X 3 month for further review and action planning or until the QA & A Committee determines compliance.		