Burned

The nursing home failed to implement its written abuse prevention policy and procedure, including: a. investigating alleged incidents of abuse, when resident 9 alleged that CNA 3 had a fist fight with resident 9 and that CNA 2 had wrung a towel soaked with hot water over resident 9's genitals; b. ensuring CNA 3 and CNA 2 were suspended pending completion of an abuse investigation; c. reporting the results of the investigation of the alleged abuse to the State Survey Agency.

These deficient practices had the potential to result in an unidentified abuse of all residents who were assigned to CNA 3 and CNA 2 and placed resident 9 at risk for the potential of ongoing abuse and resulted in resident 9 feeling of intimidation, retaliation, neglect, and decline in emotional well-being.

The nursing home also failed to ensure resident 9 was not subject to physical abuse from CNA 3 and CNA 2, failed to investigate the alleged abuse, and protect the resident from possible further abuse.

Resident 9 had an "intact cognitive response" (based on MDS assessment) and was totally dependent on staff for bed mobility, transfer, toileting, eating, and personal hygiene. During an interview, resident 9 stated she suffered pain after CNA 3 pulled the towel under her buttocks real hard during incontinence care. The resident stated a fist fight happened between her and CNA 3 because CNA 3 forced her to be cleaned, despite her objections. The resident stated that she did not report the fist fight incident to staff but reported it to her family member (FM3).

Resident 9 stated there was another incident of abuse where CNA 2 burned her by wringing a towel soaked with hot water over her private parts. The resident stated she reported this incident to FM3.

During an interview, FM3 stated the Administrator was notified of the allegations of abuse from CNA 3 and CNA 2. FM3 stated the Administrator told FM3 it will be taken care of. However, in an interview held on the following day, the Administrator stated that he was not aware of the alleged abuse incidents.

Two days later, resident 9 informed LVN 7 that she had a fist fight with CNA 3 and that something must be done. The resident stated, while crying, that the incident made her feel less than a person. The resident stated that she wanted to go home because she is scared for her life; that CNA 3 will continue the abuse. The resident stated that she did not tell anybody about the fist fight incident because she felt like the staff would retaliate against her. The resident stated she reported the abuse by CNA 3 and CNA 2 to FM3 and FM3 made complaints to the Administrator. LVN 7 said he will take care of it.

Five days later, resident 9 stated CNA 3 was assigned to her last night and that she was really scared and wanted to go home. She felt intimidated and neglected by the abuse incidents from CNA 3 and CNA 2.

Name of Nursing Home	Briarcrest Nursing Center / Provider ID: 056220
Address	5648 East Gotham Street, Bell Gardens, California
Date investigation completed	December 22, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 3; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056220/health/standard?date=2021-12-22