

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER Brighton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 361 E. Grangeville Blvd Hanford, CA 93230	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) was developed and implemented for one of five sampled residents (Resident 4) when, Resident 4's care plan was not developed and initiated for two-person assistance with transfers. This failure had the potential to result in Resident 4's care needs to not be met and placed Resident 4 at risk for falls and injuries due to inadequate staff assistance. Findings: During a concurrent observation and interview on 6/22/26 at 10:15 a.m. with Resident (Res) 4, in Res 4's room, Res 4 was observed lying in bed, dressed with a sheet covering him and his bed elevated. Res 4 stated he had been at the facility since 6/3/26 due to having neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body) in his legs and heart issues and was unable to get out of bed. Res 4 stated he was bedridden. Res 4 stated he received help to get in his wheelchair. Res 4 stated at first there were two staff members who helped him get up, now it was one person. During a review of Res 4's admission Record (AR - a summary of information regarding a patient), dated 6/22/26, the AR indicated Resident 4 was admitted to the facility from an acute care hospital on 6/3/26 with diagnoses of difficulty walking, acquired loss of limb (surgical removal of finger, toe, hand, foot, arm or leg) left great toe, type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), muscle weakness, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Res 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/9/26, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS, a test given to determine thinking and learning), score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 4 was cognitively intact. During an interview on 6/22/26 at 10:29 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Res 4 called the CNAs if he needed something. CNA 1 stated Res 4 was a two person assist. CNA 1 stated the nurses, or the therapist told the CNAs if a resident was a one or two-person assist. During a concurrent interview and record review on 6/22/26 at 11:56 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 4's Care Plan (CP), undated was reviewed. LVN 1 stated Res 4 did not have a CP for transferring Res 4. Res 4's Physical Therapy Treatment Encounter Note (EN), dated 6/4/26 was reviewed. The EN indicated Res 4 required substantial/maximum assistance for transfers. LVN 1 stated Res 4 should have had a CP for transfers. LVN 1 stated the CP was how a resident's needs were communicated with the facility, with the staff and with the State. LVN 1 stated there was a risk of injury to Res 4 if there was no CP and staff did not know how to transfer the resident. LVN 1 stated the Minimum Data Set (MDS) coordinator initiated the residents' CPs. LVN 1 stated when a resident was admitted, the Activities of Daily Living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) CPs were entered by the nurses and the MDS entered the resident's other CPs. LVN 1 (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the MDS referred to the EN of the resident assessment to enter the CPs. During an interview on 6/22/26 at 12:48 p.m. with the Director of Staff Development (DSD), the DSD stated she did in-services on transferring techniques and mechanical lift training. The DSD stated she followed up the day after orientation for skills checks on bed making and transfers. The DSD stated the CNAs could ask nursing for help with transferring residents if needed. The DSD stated she was ultimately responsible for training and making sure staff were performing safe transfers of residents. During a concurrent interview and record review on 6/22/26 at 1:00 p.m. with the MDS, Res 4's CP, undated was reviewed. The MDS stated there was no care plan initiated for transferring assistance for Res 4. The MDS stated he reviewed the resident's needs for initiating a care plan, depending on the resident's diagnoses and medication used to create the care plan. The MDS stated he reviewed the Therapist's notes, CNA documentation and Nurse documentation during admission and did a physical observation when the CNAs were taking care of the residents to see if there were any needs or assistance required. The MDS stated he or his assistant initiated the care plan for resident transfer assistance. The MDS stated there would only be two-person assistance if the resident required the use of a mechanical lift. The MDS stated if a mechanical lift was not needed it would be noted what assistance was needed, moderate or maximum assistance. The MDS stated a one or two-person assist was based on the CNA's judgement. The MDS stated the CNA should know the amount of assistance they needed for transferring residents. During an interview on 6/22/26 at 1:15 p.m. with the Director of Nursing (DON), the DON stated if a resident required a two-person transfer, the nurse was available to help the CNA if needed. The DON stated residents should have a care plan stating if a resident needed a one or two person assist with transfers. The DON stated it was not acceptable for a CNA to use their judgement to determine if a resident needed a one or two-person assist with transfers. The DON stated the CNAs were not trained to determine if resident was a one or two-person assist, and it was beyond the CNA's scope of practice. The DON stated if the CNA had any questions, the CNA could ask the Charge Nurse or DSD. The DON stated a resident's care plan was the medical necessity information of the resident and was resident-centered for the needs of the resident. The DON stated the care plan was intended for continuity of care of the residents and to be sure the residents were properly cared for. The DON stated there should have been a care plan for transferring Res 4 and the number of staff needed for assisting with Res 4's transfers. The DON stated all staff were responsible for resident safety, and the DON was ultimately responsible for the clinical safety of residents. 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, .a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		