STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35314 Based on interview, record review, and facility policy review, the facility failed to ensure staff reported an allegation of abuse for 1 (Resident #55) of 1 resident reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised in 2023, revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy revealed, 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. An Admission Record revealed the facility admitted Resident #55 on 08/01/2023. According to the Admission Record, the resident had a medical history that included diagnoses of palliative care, hemiplegia and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, urinary incontinence, and the need for assistance with personal care. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2024, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was dependent on staff for toileting hygiene and showering/bathing. The MDS revealed the resident was always incontinent of bladder and bowel. Resident #55's care plan included a focus area initiated on 08/02/2023 that indicated the resident had an activity of daily living deficit and required extensive assistance. During an interview on 08/05/2024 at 11:40 AM, Resident #55 stated one aide had been rough during care the week prior. Resident #55 stated the aide had hurt them while providing care. Resident #55 stated they had informed Certified Nurse Aide (CNA) #3 about an aide being rough. Resident #55 did not know the name of the aide. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 08/05/2024 at 1:56 PM revealed he was not aware of any reports of an aide being rough. The Administrator stated no staff had reported any concerns with Resident #55 reporting staff were being rough during care. During an interview on 08/05/2024 at 2:01 PM, CNA #3 stated Resident #55 had reported that an aide had been rough and hurt the resident during perineal care. CNA #3 stated the resident informed her on 08/04/2024, during morning rounds. CNA #3 stated she had not reported the allegations to the charge nurse or the Administrator. She stated she did inform CNA #4 about Resident #55's allegations. During an interview on 08/05/2024 at 2:07 PM, CNA #4 stated CNA #3 had informed her that Resident #55 had reported that an aide was rough and had hurt the resident. She stated she did not report the allegation to the charge nurse or the Administrator. During an interview on 08/07/2024 at 10:55 AM, the Social Service Director (SSD) stated he had received a report after surveyor inquiry that an aide had been rough with Resident #55. He stated he began the investigation and Resident #55 was interviewed. The SSD stated the resident stated they felt safe and there had not been any physical signs of abuse. The SSD stated Resident #55 reported they felt safe at the facility. During a follow up interview on 08/07/2024 at 2:38 PM, Resident #55 stated they felt safe and was not fearful of the staff. An interview with the Administrator on 08/08/2024 at 10:43 AM revealed he expected the facility staff to report any allegations of staff members being rough or hurting any of the residents. The Administrator stated the aide should have reported the allegation to the supervisors and the Abuse Coordinator immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36105 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the medication error rate was not greater than 5 percent (%). The facility had 2 medication errors out of 27 total opportunities, resulting in a medication error rate of 7.41%, affecting 2 (Resident #78 and Resident #43) of 5 residents observed during medication administration. Findings included: A facility policy titled, Medication Administration General Guidelines, dated 01/2021, revealed the section titled Medication Preparation: included 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record [MAR]. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a 'direction change' sticker to label if directions have changed from the current label. The policy further specified, Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. 1. An Admission Record indicated the facility admitted Resident #78 on 06/26/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of generalized muscle weakness. Resident #78's Order Summary Report with active orders as of 08/06/2024, contained an order dated 06/26/2024 for a multiple vitamin tablet to be given one time per day as a supplement. During an observation of medication pass on 08/06/2024 at 8:21 AM, Licensed Vocational Nurse (LVN) #1 administered one multivitamin with minerals tablet to Resident #78. During an interview on 08/06/2024 at 12:38 PM, LVN #1 stated Resident #78's order did not say the multivitamin tablet should contain minerals. She stated the order was for a multivitamin tablet without minerals. LVN #1 stated that before she gave the tablet, she should have called the doctor to verify that she could give the multivitamin with minerals. LVN #1 stated she should have triple checked that it was the correct medication to give by reading the label again before she gave it. She stated she gave the wrong medication. 2. An Admission Record indicated the facility admitted Resident #43 on 10/25/2017. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia and diabetes mellitus type 2. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43's Order Summary Report with active orders as of 08/06/2024, contained an order dated 07/15/2022 and reordered on 08/06/2024 for a multiple vitamin tablet to be given one time per day as a supplement. During an observation of medication pass on 08/06/2024 at 8:43 AM, Licensed Vocational Nurse (LVN) #2 administered one multivitamin with minerals tablet to Resident #43. During an interview on 08/06/2024 at 12:42 PM, LVN #2 stated the bottle in the cart of multivitamins with minerals was not the same medication as the order for multivitamins. She stated she should not have given Resident #43 the multivitamins with minerals, because it was not ordered, and she should have checked for a bottle of multivitamins without minerals or clarified the order before giving it. During an interview on 08/07/2024 at 10:24 AM, the Director of Nursing (DON) stated that during medication administration, she expected the nurses to match the physician's order with the label on the medication bottle to avoid errors. She stated the nurses should not have given the multivitamins with minerals until they clarified the order. During an interview on 08/07/2024 at 10:26 AM, the Administrator stated he expected the nurses to double check the medication label before giving a medication, and then give the medication according to the order.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45849 Based on observation, interview, and record review, the facility failed to ensure resident rooms measured at least 80 square (sq.) feet (ft.) per resident in 26 (Rooms 100, 102, 104, 106, 108, 110, 112, 200, 204, 206, 208, 210, 212, 214, 300, 301, 302, 303, 304, 305, 404, 406, 408, 410, 412, and 414) of 40 resident rooms in the facility. Findings included: A Client Accommodation Analysis, undated, revealed documentation of room sizes indicated the following resident rooms and corresponding square footage (sq. ft.): - In room [ROOM NUMBER], the total floor area measured 212 sq. ft. and three beds occupied the room, which provided 70.7 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 213.9 sq. ft. and three beds occupied the room, which provided 71.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 200.5 sq. ft. and three beds occupied the room, which provided 66.8 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 214.5 sq. ft. and three beds occupied the room, which provided 71.5 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 224.6 sq. ft. and three beds occupied the room, which provided 74.9 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 210.9 sq. ft. and three beds occupied the room, which provided 70.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 292.5 sq. ft. and four beds occupied the room, which provided 73.1 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 222.6 sq. ft. and three beds occupied the room, which provided 74.2 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 220 sq. ft. and three beds occupied the room, which provided 73.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 222 sq. ft. and three beds occupied the room, which provided 74 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 224 sq. ft. and three beds occupied the room, which provided 74.7 sq. ft. of space per resident. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	- In room [ROOM NUMBER], the total floor area measured 222 sq. ft. and three beds occupied the room, which provided 74 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 224 sq. ft. and three beds occupied the room, which provided 74.7 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 224 sq. ft. and three beds occupied the room, which provided 74.7 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 209 sq. ft. and three beds occupied the room, which provided 69.7 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 214 sq. ft. and three beds occupied the room, which provided 71.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 220 sq. ft. and three beds occupied the room, which provided 73.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 224 sq. ft. and three beds occupied the room, which provided 74.7 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 220 sq. ft. and three beds occupied the room, which provided 73.3 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 297.6 sq. ft. and four beds occupied the room, which provided 74.4 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 236.3 sq. ft. and three beds occupied the room, which provided 78.8 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 234.3 sq. ft. and three beds occupied the room, which provided 78.1 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 234.3 sq. ft. and three beds occupied the room, which provided 78.1 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 234.3 sq. ft. and three beds occupied the room, which provided 78.1 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 234.3 sq. ft. and three beds occupied the room, which provided 78.1 sq. ft. of space per resident. - In room [ROOM NUMBER], the total floor area measured 236.4 sq. ft. and three beds occupied the room, which provided 78.8 sq. ft. of space per resident. During the initial pool process on 08/05/2024, 24 residents were interviewed. No residents expressed concerns with room size. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 08/07/2024 at 11:41 AM, the Maintenance Director stated there had not been any concerns voiced about the rooms not being large enough. The Maintenance Director confirmed the measurements provided were accurate for the room sizes. During an interview on 08/08/2024 at 10:45 AM, the Director of Nursing (DON) stated that the facility had a waiver for the rooms that did not meet the required 80 sq. ft. per resident. The DON stated her expectation was that resident care was provided in those rooms in a safe manner while maintaining resident privacy. The DON stated she was not aware of there being any issues providing care due to the size of the rooms. During an interview on 08/08/2024 at 11:04 AM, the Administrator stated there was no policy for room size. The Administrator stated his expectation was that there should not be any difference in care for those residents residing in the smaller rooms. The Administrator stated the current room sizes allowed for care and privacy. The Administrator stated he had never received any complaints of staff not being able to provide care due to the room size.