STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055685	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place Spring Valley	9009 Campo Road Spring Valley, CA 91977

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on interview and record review, the Facility failed to report allegations of abuse by staff members against one resident, Resident 1. Resident 1 reported feeling violated while in the Facility. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses that included acute osteomyelitis left ankle and foot (inflammation of bone), anxiety (a condition which creates excessive worry or nervousness about real or perceived threats), alcohol abuse and withdrawal (unhealthy consumption of alcohol accompanied by physical and psychological symptoms when alcohol consumption stops), and unspecified psychosis not due to a substance or known physiological condition (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) . On 5/2/24 at 12:36 P.M. a telephone interview was conducted with Resident 1 who was no longer residing in the Facility. Resident 1 stated, In the past week one of the nurses drug [sic] her finger up my inner thigh to wake me up during the night shift . I reported to the old and new social worker and to the Director of Nursing and administrator. I talked to the ombudsman with the administrator and social worker. The Director of Nursing herself sexually made advances on me. I am so hurt and violated. I thought the administrator was going to handle all of this. A review of an email dated 10/26/23 at 3:58 P.M. provided by Resident 1 was reviewed. The email was sent to the Facility Social Worker (SW), Administrator (ADM) and Director of Nursing (DON). The email indicated, To all: I (Resident 1) have put up with assaults, harassment, women entering my secured and safe 10 by 10 (WITH curtain DRAWN) and have asked to have an INCIDENT REPORT DONE. I ASKED (name of administrator) AND SOCIAL SERVICES FOR THE INCIDENT REPORTS. A review of an email dated 4/23/24 at 6:52 A.M. provided by Resident 1 was reviewed. The email was sent to the Facility Administrator (ADM), Director of Nursing (DON) and Social Worker (SW). The email indicated, This morning at 5:50 a.m. [sic] (name) doesn ' t knock comes in runs her fingers up from my ankle to my knees.I ' ve texted DON, (name of social worker) told (name) another med nurse and now I want to file a report as soon as anyone of authority comes to work. Once again ive [sic] got to deal with 100% PERVERT and illegal. Why is she touching me. No knock, nothing! Just touching and fondling. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055685	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place Spring Valley	9009 Campo Road Spring Valley, CA 91977

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an email dated 4/23/24 at 9:13 A.M. provided by Resident 1 was reviewed. The email was sent to the Facility ADM, SW and DON. The email indicated, Just straight to rubbing FINGERS from my ANKLE past my KNEE by your employee (name) MED NURSE at 5:50 a.m. [sic] I asked her 3 times to leave AFTER being CAUGHT TOUCHING ME. She THEN threatened me telling me she ' d hold my medications in the future. An interview and concurrent record review were conducted with the Administrator on 5/2/24 at 3:35 P.M. The ADM stated, I did an investigation regarding (name) about one week ago, I knew the allegation was false so I didn ' t report it. The facility policy entitled Abuse - Reporting and Investigations revised 12/21/23 indicated, The Administrator or designated representative will notify law enforcement by telephone immediately, or as soon as practicably possible, but no longer than (2) hours of initial report. The Administrator or designated representative will send a written SOC341 (a report of suspected or known abuse) report to the Ombudsman and Law Enforcement and CDPH Licensing and Certification within twenty-four (24) hours. The facility policy entitled Abuse - Prevention, Screening, & Training Program revised July 2018 indicated, The Facility provides and staff sign an acknowledgement of their responsibility to report alleged or suspected abuse, neglect, exploitation, misappropriation of resident property and/ or mistreatment.