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	08/14/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and their families with a written Notice of Transfer/Discharge for three of three residents (Resident 1, 2, and 3), when reviewed for discharge. These failures had the potential for residents to experience increased anxiety, when last-minute discharges were conducted, with no ability to appeal the discharge. Findings:An unannounced visit was made to the facility on 8/14/25, in response to a complaint involving a discharge.1. Resident 1 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease, stage 4, (severe kidney damage with significantly reduced kidney function), per the facility's admission Record.Resident 1 had a Responsible Party (RP-a person designated to make medical and financial decisions on the resident's behalf) listed on the admission RecordOn 8/14/25, Resident 1's clinical record was reviewed.According to the discharge Minimum Data Set, (MDS-a clinical assessment tool), dated 7/25/25, Resident 1 had a cognitive score of 12, indicating cognition was moderately impaired. According to the facility's nursing notes, titled Discharge summary, dated [DATE] at 12:26 P.M., Resident 1 was discharged to an assisted living facility, via medical transport.There was no documented evidence that a written Notice of Transfer/Discharge was provided to the resident or the RP, prior to discharge.2. Resident 2 was admitted to the facility on [DATE], with diagnoses which included cellulitis (an infection of the skin and subcutaneous tissue), per the facility's admission Record.On 8/14/25, Resident 2's clinical record was reviewed.According to Resident 2's discharge MDS, dated [DATE], a cognitive score of 13 was listed, indicating cognition was intact.The facility's Discharge Planning Review Form, dated 7/11/25, indicated Resident 2 was being discharged to an Independent Living Facility, for a lower level of care.There was no documented evidence that a written Notice of Transfer/Discharge was provided to the resident, prior to discharge.3. Resident 3 was admitted to the facility on [DATE], with diagnoses which included pneumonia (Infection in the lungs), per the facility's admission Record.On 8/14/25, Resident 3's clinical record was reviewed.According to Resident 3's discharge MDS, dated [DATE], a cognitive score of 14 was listed, indicating cognition was intact.The facility's Discharge Planning Review Form, dated 7/18/25, indicated Resident 3 was being discharged to an Assisted Living Facility, for a lower level of care.There was no documented evidence that a written Notice of Transfer/Discharge was provided to the resident, prior to discharge.An interview and record review was conducted with the Director of Nursing (DON) on 8/14/25 at 10:28 A.M. The DON stated Notices of Transfer/Discharge should be provided in writing to residents within 30 days of discharge. The DON stated that a copy of the signed Notice was placed in the medical record. The DON reviewed Resident 1,2, and 3's medical record and could not locate any documentation that a Notice of Transfer/Discharge was provided. The DON stated providing a Notice of Transfer/Discharge was important, so residents and their families knew what was occurring and that preparations were being made in advance. The DON stated the Notice also helped prepare the residents and decreases anxiety, incorporating them into the discharge planning process. The DON stated if a Transfer/Discharge Notice was not provided, it could contribute to a rushed, unsafe discharge. An interview was conducted with Licensed Nurse 1 (LN 1) on 8/14/25 at 1:58 P.M. LN 1 stated Notice of Transfer/Discharge's were usually provided by the Social Service Director (SSD), unless the resident was going to the hospital, then the LNs completed the Notices. LN 1 stated Notice for Transfer/Discharges were important, so residents were aware of what was coming next, and that staff were preparing for the transfer or discharge.An interview was conducted with the SSD on 8/19/25 at 1:58 P.M. The SSD stated she was aware a written Notice for Transfer/Discharge were required to be provided to residents and their RP, 30 days prior to discharge. The SSD stated she was not always able to provide a Notice prior to Discharge, because she, had been spread really thin during July and was not able to provide all residents being their discharged notices.According to the facility's policy, titled Discharge and Transfer of Residents, dated February 2025, .5. Prior to discharge, the Facility will provide the resident/resident representative with the Notice of Proposed Transfer and Discharge document. 6. A copy of the Notice of Proposed Transfer and Discharge will be placed in the Resident's medical record and a copy faxed to the Ombudsman.According to the facility's policy, titled Resident Rights, dated January 2012, .1, State and Federal laws guarantee basic rights to all residents of the Facility.A, Be informed about what rights and responsibility's he or she has; .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement person-centered care plans related to resident discharges for two of three residents, (Resident 1 and Resident 3), when reviewed for dischargesThis failure had the potential for staff to be uninformed of the residents' wishes for discharge, resulting in an uncoordinated effort for a planned and organized discharge. Findings:An unannounced visit was made to the facility on 8/14/25, in response to a complaint involving a discharge.1. Resident 1 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease stage 4, (severe kidney damage and significantly reduced kidney function), per the facility's admission Record.Resident 1 had a Responsible Party (RP-a person designated to make medical and financial decisions on the resident's behalf) listed on the admission RecordOn 8/14/25, Resident 1's clinical record was reviewed.According to the discharge Minimum Data Set, (MDS-a clinical assessment tool), dated 7/25/25, Resident 1 had a cognitive score of 12, indicating cognition was moderately impaired. According to the facility's nursing notes, titled Discharge summary, dated [DATE] at 12:26 P.M., Resident 1 was discharged to an assisted living facility, via medical transport.The discharge care plan was created by the Social Service Director (SSD) on the day of discharge, dated 7/25/25, listed interventions such as, Establish a pre-discharge plan and coordinate discharge.2. Resident 3 was admitted to the facility on [DATE], with diagnoses which included pneumonia (Infection in the lungs), per the facility's admission Record.On 8/24/25, Resident 3's clinical record was reviewed.According to Resident 3's discharge MDS, dated [DATE], A cognitive score of 14 was listed, indicating cognition was intact.The Facility's Discharge Planning Review Form, dated 7/18/25, indicated Resident 3 was being discharged to an Assisted Living Facility, for a lower level of care.There was no documented evidence that a discharge care plan had been developed or implemented.An interview and record review was conducted with the Director of Nursing on 8/14/25 at 10:28 A.M. The DON stated discharge care plans should be developed when the resident was admitted , so staff could collaborate with the residents. The DON reviewed Resident 1's care plan and stated it should never have been developed on the day of discharge, because it would be ineffective. The DON reviewed Resident 3's records and could not locate a discharge care plan. The DON stated since there was no discharge care plan, there was a possibility the discharge was not safe or organized.An interview was conducted with Licensed Nurse 1 (LN 1) on 8/14/25 at 11:20 A.M. LN 2 stated discharge care plans were important, so staff were aware of the discharge plans. LN 1 stated discharge care plans helped staff work towards the residents' goal of leaving the facility and to help prepare for leaving. LN 1 stated if discharge care plans were not developed, the discharge could be disorganized and rushed, without thorough preparations being made.An interview was conducted with the Social Service Director (SSD) on 8/19/25 at 1:58 P.M. The SSD stated she did recall Resident 1, his RP, and the discharge. The SSD stated she did develop the discharge care plan on the day of Resident 1's discharge, because she noticed he did not have one. The SSD stated the care plan was inadequate and not appropriate because it should have been developed shortly after admission. According to the facility's policy, titled Transfer and Discharge, dated October 2017, .I. Discharge Planning: A. Discharge planning will begin on the resident's admission to the Facility.H. Social, Services will document the discharge planning, preparation, and the president's post discharge needs.