

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Brighton Place Spring Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review, the facility failed to report an allegation of financial abuse between a resident (Resident 1) and a Certified Nursing Assistant (CNA 1) to the California Department of Public Health (CDPH) within the 24 hour time requirement. This failure had the potential to delay investigation and affect the physical and psychosocial wellbeing of the resident. Findings: According to an undated Face Sheet, Resident 1 was readmitted to the facility on [DATE] with diagnoses to include paraplegia (the loss of function to both legs) and schizoaffective disorder (a complex mental health problem). According to the physician's History and Physical note, dated 5/5/26, Resident 1 could make his needs known, but could not make medical decisions. According to the Brief Interview for Mental Status (BIMS, an assessment tool), dated 5/22/26, Resident 1 had moderately impaired cognition. A complaint was received by the California Department of Public Health indicating Resident 1 had reported an unknown amount of money was missing from a personal bank account. Resident 1 had reported that a certified nurse assistant (CNA) had purchased food using his debit card number. An interview was conducted with Resident 1 on 6/9/26 at 10:55 A.M. Resident 1 stated he had asked CNA 1 to help order food from a food delivery application (app). Resident 1 stated CNA 1 had used her personal phone with his debit card number for payment to order food delivery for him. Resident 1 stated CNA 1 then went home, forgetting his debit card was on her phone, and her child had then ordered food using the same app and his debit card. Resident 1 stated CNA 1 had apologized and returned the money, and he did not want her to get in trouble. Resident 1 stated he had reported this information to the Social Services Director (SSD) at the facility. An interview was conducted with the SSD on 6/9/26 at 11:30 A.M. The SSD stated Resident 1 had asked to speak with her on 5/30/26. The SSD stated Resident 1 had told her about CNA 1 ordering the food with her phone using his debit card, and about the additional purchases made from CNA 1's home. The SSD stated Resident 1 had told her the money had been paid back to him. Per the SSD, she educated Resident 1 about not sharing his debit card information with anyone. The SSD stated she informed the Administrator (Admin) about the incident on the same day. An interview was conducted with the Admin on 6/9/26 at 11:45 A.M. The Admin stated he was the abuse coordinator for the facility. Per the Admin, he was aware of the incident reported by Resident 1. The Admin stated Resident 1 occasionally acted inappropriately due to his illness in order to get attention. The Admin stated he had not considered the incident to potentially be financial abuse, and he did not report the incident to CDPH. The Admin stated he should have reported the incident to CDPH as soon as it was reported to him, but he had not done so. A telephone interview was conducted with CNA 1 on 6/10/26 at 7:15 A.M. CNA 1 stated she had not been assigned to work with Resident 1 in a long time. CNA 1 stated she had never ordered food delivery for Resident 1 using her phone and had never assisted Resident 1 in ordering food from his phone or tablet. CNA 1 stated she had never paid money to Resident 1. CNA 1 stated she had not been disciplined for the reported incident, but she and her coworkers had been educated on identifying and preventing abuse. A follow up telephone interview was conducted with the Admin on 6/10/26 at 8:30 A.M. The Admin stated CNA 1 had provided access to her phone, including the food delivery app and (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	payments. Per the Admin, there were no purchases made using Resident 1's debit card number. The Admin stated Resident 1 had admitted he was trying to get the SSD's attention by reporting the incident. The Admin stated he should have identified the situation as potentially being financial abuse, and reported the incident to CDPH, but he had not done so. A follow up interview and document review was conducted with the SSD on 6/15/26 at 2:30 P.M. The SSD stated rather than educating Resident 1 regarding giving his debit card information to staff, she should have immediately reported the incident to the Admin who was the Abuse Coordinator for the facility. The SSD reviewed the facility's Abuse Prevention and Management policy and stated she had not identified the situation as abuse and had not reported the incident to the Admin as a possible abuse allegation. According to a facility policy, revised 5/30/24 and titled Abuse Prevention and Management, .The facility will report all allegations of abuse.as required by law and regulations to the appropriate agencies.Reports of resident abuse.are promptly reported.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an allegation of financial abuse for one of two residents reviewed for abuse (Resident 1). This failure had the potential to place residents at risk for abuse. Findings:According to an undated Face Sheet, Resident 1 was readmitted to the facility on [DATE] with diagnoses to include paraplegia (the loss of function to both legs) and schizoaffective disorder (a complex mental health problem).According to the physician's History and Physical note, dated 5/5/26, Resident 1 could make his needs known, but could not make medical decisions.According to the Brief Interview for Mental Status (BIMS, an assessment tool), dated 5/22/26, Resident 1 had moderately impaired cognition.A complaint was received by the California Department of Public Health indicating Resident 1 had reported missing money from a personal bank account. Resident 1 had reported that a CNA had purchased food using his debit card number. An interview was conducted with Resident 1 on 6/9/26 at 10:55 A.M. Resident 1 stated he had asked certified nurse assistant (CNA) 1 to help order food from a food delivery application (app). Resident 1 stated CNA 1 had used her personal phone with his debit card number for payment to order food delivery for him. Resident 1 stated CNA 1 then went home, forgetting his debit card was on her phone, and her child had then ordered food using the same app and his debit card. Resident 1 stated CNA 1 had apologized and returned the money, and he did not want her to get in trouble. Resident 1 stated he had reported this information to the Social Services Director (SSD) at the facility, who advised him not to share his debit card information with anyone. Resident 1 stated nobody else from the facility had discussed this with him. An interview was conducted with the SSD on 6/9/26 at 11:30 A.M. The SSD stated Resident 1 had asked to speak with her on 5/30/26. The SSD stated Resident 1 had told her about CNA 1 ordering the food with her phone using his debit card, and about the additional purchases made from CNA 1's home. The SSD stated Resident 1 had told her the money had been paid back to him. Per the SSD, she educated Resident 1 about not sharing his debit card information with anyone. The SSD stated she informed the Administrator (Admin) about the incident, but she had not spoken to CNA 1 or conducted an investigation. An interview was conducted with the Admin on 6/9/26 at 11:45 A.M. The Admin stated he was the abuse coordinator for the facility. Per the Admin, he was aware of the incident reported by Resident 1. The Admin stated Resident 1 occasionally acted inappropriately due to his illness to get attention. The Admin stated he had not considered the incident to potentially be financial abuse, and he had not spoken to Resident 1 or asked CNA 1 any questions about her involvement. The Admin stated he should have conducted an investigation to obtain more details to determine whether abuse had occurred or not. A telephone interview was conducted with CNA 1 on 6/10/26 at 7:15 A.M. CNA 1 stated she had not been assigned to work with Resident 1 in a long time. CNA 1 stated she had never ordered food delivery for Resident 1 using her phone and had never assisted Resident 1 in ordering food from his phone or tablet. CNA 1 stated she had not been disciplined for the reported incident, and she had not been suspended from her job. CNA 1 stated nobody at the facility had requested to see her phone or asked her any questions regarding using Resident 1's debit card. A follow up telephone interview was conducted with the Admin on 6/10/26 at 8:30 A.M. The Admin stated CNA 1 had provided access to her phone, including the food delivery app and payments. Per the Admin, there were no purchases made using Resident 1's debit card number. The Admin stated Resident 1 had admitted he was trying to get the SSD's attention by reporting the incident. The Admin stated as the facility's Abuse Coordinator, he should have suspended CNA 1 and conducted an investigation, but he had not done so. A follow up interview and document review was conducted with the SSD on 6/15/26 at 2:30 P.M. The SSD stated she should have asked Resident 1 for proof of the missing funds and spoken to CNA 1 to assist with the investigation. The SSD stated the Admin was the Abuse Coordinator for the facility. The SSD reviewed the facility's Abuse Prevention and Management policy and stated CNA 1 should have been (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspended while she and the Admin conducted an investigation, but they had had not done so. According to a facility policy, revised 5/30/24 and titled Abuse Prevention and Management, .Reports of resident abuse.are promptly reported and thoroughly investigated.when the Administrator.receivees a report of an allegation of abuse.will initiate an investigation immediately.if the suspected perpetrator is an employee, remove the employee immediately from the care of the resident(s) and immediately suspend the employee pending the outcome of the investigation.		