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	05/08/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39220 Based on observation, interview, and record review, the facility failed to maintain resident room walls in a clean, homelike, and visually appealing manner for two of 24 residents (Resident 47 and Resident 54), reviewed for homelike environment. This failure had the potential for residents to feel not valued or appreciated. Findings: 1. An observation was conducted during initial tour of Resident 54's room on 5/5/25 at 8:46 A.M. The lower left side of the wall, near the head of the bed, had a large area of discoloration and peeling paint. This area of the wall was closest to the room entrance and visible when standing near the foot of the bed. An observation and interview was conducted with Licensed Nurse 1 (LN 1) as she sat on the right side of Resident 54's bed, assisting the resident with breakfast on 5/6/25 at 8:09 A.M. LN 1 was asked to look at Resident 54's wall, near the head of the bed. LN 1 observed the left side of the wall, near the head of the bed and stated, Oh, that doesn't look good and should be fixed. An interview was conducted with Certified Nursing Assistant 1 (CNA 1) of Resident 54's room on 5/7/25 at 3:46 P.M. CNA 1 stated Resident 54's daughter visited the resident about once a week. CNA 1 stated the daughter usually sat next to the resident's bed when visiting, facing the head of the bed. CNA 1 stated if something needed to be fixed in the resident's room, staff were expected to document it in the maintenance log, kept at the nurse's station. CNA 1 stated maintenance staff checked the maintenance book several times a day and would sign off the book, when the repair was fixed. An observation and interview of Resident 54's bedroom wall was conducted with CNA 1, at 5/7/25 at 3:52 P. M. Resident 54's bed was empty and made. CNA 1 looked at the left side of the wall near the head of the bed and stated, Oh, that does not look good. The wall does not look presentable or homelike. 2. An observation was conducted during initial tour of Resident 47's room on 5/5/25 at 9:40 A.M. The lower right side of the wall, near the head of the bed had a large area of discoloration and peeling paint. The area of the wall was furthest from the front door entrance and had a cushioned chair next to it for visitation. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA 1 on 5/7/25 at 3:46 P.M. CNA 1 stated Resident 47's son visited every afternoon with the resident inside the room. An observation and interview was conducted with CNA 1 of Resident 47's room on 5/7/25 at 3:50 P.M. CNA 1 stated the residents' wall did not look good and it should be painted and fixed. CNA 1 stated the wall did not appear homelike or welcoming. A review of the maintenance book, stored at the East nurse's station was reviewed on 5/7/25 at 3:54 P.M. The maintenance book was reviewed from 12/1/24 through 5/4/25, and no documentation was listed for Residents 54's or 47's walls to be repair. An interview was conducted with the Director of Maintenance (DM) on 5/7/25 at 4:08 P.M. The DM stated he routinely inspected resident rooms. The DM stated they made repairs to resident rooms on the west unit and were getting ready to do repairs on the east unit. The DM stated he had not documented the repairs needed on the east unit. An observation and interview of Resident 54's room was conducted with the DM on 5/7/25 at 4:12 P.M. The DM stated the resident's room wall looked bad and needed to be repaired. An observation and interview of Resident 47's room was conducted with the DM on 5/7/25 at 4:15 P.M. The DM stated, This room also did not look good and the walls were not homelike. An interview was conducted with the Director of Nursing (DON) on 5/8/25 at 8:57 A.M. The DON stated all resident rooms should be presentable and homelike. The DON stated she expected staff to document issues in the unit's maintenance book when repairs were identified. According to the facility's policy, titled Resident Room and Environment, dated January 2012, .The facility provides residents with a safe, clean, comfortable, and homelike environment 1. The Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order . According to the facility's policy, titled Maintenance-Work Orders, dated January 2012, .Maintenance work orders shall be completed in an effort to sustain maintenance services as a priority .III. Work order request are to be placed in a designated location at the nurses' station. A. Work orders are to be picked up daily by Maintenance Staff .

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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** 39220 Based on observation, interview, and record review, the facility failed to develop a care plan related to hospice (end of life), care for one of one resident (Resident 47), reviewed for hospice care. This failure had the potential for Resident 47 to receive inconsistent care by staff. Findings: Resident 47 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. Resident 47's clinical record was reviewed on 5/5/25: According to the physician's order, dated 4/29/25, .Admit to (name) hospice . There was no documented evidence a care plan for hospice care had been developed. An observation of Resident 47 was conducted on 5/5/25 at 3:26 P.M., as she laid in bed, covered with a personal blanket. Resident 47 was asleep with her hair combed and placed in a bun on top of her head. Many personal items were in the room, such as decorations and family photos. An interview and record review was conducted with Licensed Nurse 2 (LN 2) on 5/6/25 at 3:52 P.M. LN 2 stated care plans were important for staff communication and to guide consistent resident care. LN 2 reviewed Resident 47's clinical record and could find no documented evidence a hospice care plan had been developed or implemented when Resident 47 was admitted to hospice. LN 2 stated by not developing a care plan related to hospice, staff interventions were not being implemented consistently. An interview was conducted with LN 3 on 5/6/25 at 4:02 P.M. LN 3 stated care plans were important so resident needs could be identified. LN 3 stated when residents were admitted to hospice, the LN taking the order should immediately develop a hospice care plan. LN 3 stated if a care plan was not developed, then the residents' needs were not being met. An interview and record review was conducted with the Director of Nursing (DON) on 5/6/25 at 4:08 P.M. The DON stated when residents were admitted to hospice, the hospice agency developed a care plan, and the facility developed its own care plan, in order to have consistent, coordinated care among staff. The DON reviewed Resident 47's clinical record and stated a care plan for hospice had not been developed, and it should have been. The DON stated by not having a hospice care plan, staff would not be on the same page when providing care. According to the facility's policy, titled Comprehensive Person-Centered Care Planning, dated August 2023, . 4. Comprehensive Care Plan .b. Additional changes or updates to the residents' comprehensive care plan will be made based on the assessed needs of the resident . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy, titled Hospice Care of Residents, dated January 2012, .III. If the resident and/or surrogate decision maker decides to utilize hospice care .B. The Hospice and Facility will collaborate on a Care Plan for the resident .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review, the facility failed to change a peripheral intravenous catheter (PIV-a tube inserted into a vein used to draw blood and administer medications) per physician's order. This failure had the potential to place Resident 36 at further risk for infection. According to the Admission Record, Resident 36 was admitted on [DATE] with diagnoses which included severe sepsis (an illness in which the body had an extreme response to an infection), urinary tract infection, and bacteremia (an infection in the bloodstream). On 5/5/25 at 10:29 A.M., an observation was conducted inside Resident 36's room. Resident 36 had a PIV catheter inserted into his left arm. The PIV was covered with a transparent dressing and was dated 4/29/25. On 5/6/25 at 10:10 A.M., a concurrent observation and record review was conducted with Licensed Nurse (LN) 3. LN 3 stated 4/29/25 was the date the PIV was inserted. A review of Resident 36's physician's order dated 4/29/25 indicated, Change peripheral IV line and dressing on Left arm every 48 hours. The order indicated the IV line and dressing was scheduled to be rotated on 5/1/25, 5/3/25, and 5/5/25. LN 3 stated, It hasn't been changed since the 29th. It should have been changed last on 5/5/25. [The PIV site] is rotated to make sure the line isn't clogged and to prevent infection . On 5/7/25 at 2:50 P.M., a concurrent observation and interview was conducted with LN 9 in Resident 36's room. Resident 36 had the PIV on the left arm, which was still dated 4/29/25. LN 9 stated Resident 36's IV should have been changed on the scheduled days. LN 9 stated, .It should have been changed to prevent infection, and to double check that the IV line was still functional. It's important to have been changed because it was a doctor's order, and we need to meet the goal for [Resident 36]'s care . On 5/8/25 at 11:34 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the date of 4/29/25 on Resident 36's IV dressing indicated the IV was not changed per physician's orders. The DON stated, It should have been changed because the protocol here is to change it per the doctor's orders . The DON stated the resident was at risk for further infection because the IV line and dressing were not changed. During a review of the facility ' s undated policies and procedure (P&P) titled, Intravenous Therapy, indicated, all dressing changes will be labeled (time, date, and initials) and documented in medical record on IV medication record .the licensed nurse will check physician's order for the completeness .Complete orders include: 7. Site rotation .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to document a rationale for the use of oxygen for one of three residents (Resident 39) reviewed for oxygen therapy. This failure had the potential to place Resident 39 at risk for unnecessary treatments and services. Resident 39 was readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the lungs), per the facility's Admission Record. An observation and interview with Resident 39 was conducted on 5/5/25 at 11:24 A.M. Resident 39 was in bed, with a clear plastic oxygen tube under his nose. Resident 39 stated he used the oxygen most of the time because he had COPD. Resident 39 stated he went out of the building three times a week for a medical appointment, and he did not use the oxygen tube for those trips. Resident 39 stated it would not be safe to go to the appointments with oxygen, and it was a short trip so he was fine not using the oxygen. A record review was conducted of Resident 39's electronic health record (EHR) on 5/6/25. Resident 39's Brief Interview for Mental Status (BIMS) score was 14, indicating intact cognition. Per a physician's order, dated 12/31/24, Resident 39 was to receive oxygen to keep oxygen saturation levels (the amount of oxygen in the blood, with a normal range of 95-100%) at or above 92%. The physician's order requested staff to specify a diagnosis or reason for oxygen use. Resident 39's oxygen saturation levels were reviewed on the Medication Administration Record (MAR). For April 2025, Resident 39's oxygen saturation levels were always above 92% when measured on oxygen, and when measured on room air (without oxygen). The MAR had no documentation as to the reason for oxygen use. On 5/6/25 at 10:20 A.M., and on 5/8/25 at 10 A.M., an observation of Resident 39 was conducted. Resident 39 was returning from a medical appointment and was being wheeled into the facility in a wheelchair. Resident 39 did not have the oxygen tube under his nose. On 5/8/25 at 10:23 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 39 was on oxygen to treat his COPD. LN 11 stated every order for a medication or treatment required an indication for use, or a diagnosis. LN 11 reviewed the physician's order, and stated there was no indication or diagnosis for the use of oxygen. Per LN 11, without the indication for use, staff would not know what the oxygen was for. LN 11 stated since the physician had ordered the oxygen, it had to be on all the time, even during transportation to appointments. LN 11 stated, We made a mistake. It needs to be fixed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 10:53 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated all oxygen orders required a rationale for use. The DON stated if the physician wanted the resident to use oxygen at all times, the facility should send him to appointments with a portable oxygen tank. Per a facility policy, revised November 2017 and titled Oxygen Therapy, Purpose: To ensure the safe storage and administration of oxygen .Licensed Nursing staff will administer oxygen as prescribed . Administer oxygen per physician order .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to list and monitor specific behaviors for the use of a psychotropic medication (a drug that affects mental processes, mood, behavior, or perception), to determine the necessity of the medication for two of five residents (Resident 9 and Resident 48), reviewed for unnecessary medication. These failures had the potential for Resident 9 and Resident 48 to receive unnecessary medications. Findings: 1. Resident 9 was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (progressive memory loss) and suicidal ideations (when one thinks or plans to hurt themselves), per the facility's Admission Record. An observation was conducted with Resident 9 on 5/5/25 at 9:09 A.M., as he wheeled himself back from the smoking patio. Resident 9 had several burn holes in the middle of his sweatshirt. Resident 9's clinical record was reviewed on 5/6/25: According to the admission Minimal Data Set (MDS-a clinical assessment tool), dated 4/2/25, Resident 9 had a cognitive score of 12, indicating moderately impaired cognition. The Mood Assessment score was 16, indicating mood symptoms were present nearly every day. According to the physician's order, dated 3/26/25, Sertraline HCL (used to treat depression) 50 milligrams (mg) one time a day for depression. No specific behavior was listed for monitoring such as: excessive crying, verbalization of wanting to hurt themselves, or self isolation. No behavior monitoring was listed for staff to document when specific behaviors occurred. No side effect monitoring was listed such as headache, nausea, dry mouth, feeling sleepy. The following physician's order were added on 4/4/25, .Trazadone HCL (used to treat depression and anxiety) 50 mg one tablet by mouth at bedtime for depression .Depakote ER (used to treat bipolar disorder), 250 mg one tablet by mouth one time a day for Mood Stabilizer . No specific behaviors were listed in the physician's order for monitoring such as: severe mood changes, excessive crying, verbalization of wanting to hurt themselves, or self isolation. No behavior monitoring was listed for staff to document when specific behaviors occur. No side effects monitoring was listed such as: headache, nausea, dry mouth, feeling sleepy. Resident 9's Medication Administration Record (MAR) was reviewed from 4/1/25 through 5/6/25. There was no documented evidence specific behaviors or side effects were being monitored by staff for Sertraline, Trazadone and Depakote. According to the care plan, titled Risk for adverse reaction related to polypharmacy and side effects, revised 3/28/25, .Antidepressant drugs; interventions included: Closely monitor for clinical worsening and for emergence of suicidal thoughts and behaviors. Request physician to review and evaluate medication. Review Pharmacy Consultant recommendations . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the care plan, titled 4/3/25, interventions included: administer psychotropic medications as ordered and monitor. According to the facility's Informed Consent for Sertraline HCL 50 mg, dated 3/26/25, the physician listed no specific behaviors to monitor. According to the facility's Informed Consent for Trazadone 50 mg , dated 4/3/25, the physician listed, Diagnosis depression as exhibited by sleeplessness, statements of feeling sad, hopelessness and Depakote ER 250 mg, dated 4/3/25, with no specific behaviors listed for Depakote. An interview was conducted with Licensed Nurse 4 (LN 4) on 5/7/25 at 8:31 A.M. LN 4 stated monitoring behaviors and side effects should always be part of the physician's order when administering psychotropic medications. LN 4 stated each shift should monitor for the specific behaviors listed by the physician and document those behaviors or side effects on the MAR. LN 4 stated it was important to document the number of specific behaviors, so the physician could evaluate the frequency each month to determine if the medication was really needed. An interview and record review was conducted with LN 5 on 5/7/25 at 8:58 A.M. of Resident 9's MAR. LN 5 stated Resident 9 should have specific behaviors listed for each psychotropic medication ordered. LN 5 stated monitoring and documenting the specific behaviors in the MAR was important to determine if the medication was really needed. LN 5 stated there was no monitoring of behaviors or side effects listed in Resident 9's MAR, and there should be. An interview and record review was conducted with the Pharmacy Consultant (PC) on 5/7/25 at 2:25 P.M. of the April 2025 Medication Regimen Review (MRR- when a pharmacist conducts a thorough examination of a resident's medications to identify and address potential problems). The PC stated when he conducted his monthly MRR, he did look at physician's order and the MAR. The PC stated whenever a psychotropic medication was ordered, the physician should list a specific behavior for staff to monitor for. The PC stated staff monitoring of behaviors was important to determine if the medication was working, if it was really needed, or if the dose needed to be adjusted. The PC reviewed the April MRR for Resident 9 and stated, I missed it completely. The PC stated it was his responsibility to bring the omission of specific behavior monitoring to the facility's attention. The PC stated he missed it and the facility and physician relied on him to capture these mistakes, so they could be corrected. An interview was conducted with the Director of Nursing (DON) on 5/8/25 at 8:57 A.M. The DON stated specific behaviors needed to be listed for all residents on psychotropic medication for monitoring, along with possible side effects. The DON stated if staff were not monitoring behaviors, there was the potential for harm because the medication might be not even be needed. The DON stated this could then be considered an unnecessary medication, which could have damaging, long term side effects. According to the facility's policy titled Behavior/Psychoactive Drug Management, November 2018, .F. Any order for psychoactive medications must include; .v. Specific Behavior manifested .H. Parameters for using Anti-Psychotics: .ii. The residents behavior symptoms should meet at least one of the following criteria in order to justify the use of an anti-psychotropic medication: .b. the behavioral symptoms present a danger (documented) to the resident or others; .Monitoring for side effects: 1. Depending on the specific classification of psychoactive medication the resident should be observed and/or monitored for side effects and adverse consequences . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49330 2. According to the facility's Admission Record, Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encephalopathy (a condition which causes a disturbance in the brain's functioning, affecting thinking skills and memory) and major depressive disorder (a mental illness causing feelings of sadness). During a record review on 5/6/25, Resident 48's physician's order, dated 1/17/25, indicated quetiapine (an antipsychotic medication) for schizophrenia. No specific behaviors were listed for staff monitoring. On 5/6/25 at 8:35 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 6. CNA 6 stated he was familiar with Resident 48 and had provided care for him in the past. CNA 6 stated Resident 48 had behaviors of yelling out and calling out someone's name, .but that's it. I've never seen him aggressive or violent. He will just yell out names . CNA 6 stated he was not aware of Resident 48 having any episodes of delusions or hallucinations. On 5/7/25 at 8:14 A.M., a telephone interview was conducted with Family Member (FM) 1. FM 1 stated Resident 48 seemed confused, but she had not observed any violent behavior, delusions, or hallucinations. On 5/7/25 at 9:27 A.M., an interview was conducted with the Minimum Data Set (MDS-an assessment tool) Nurse (MDSN). The MDSN stated the criteria for psychotropic medication required documentation and monitoring of a specific behavior. On 5/8/25 at 8:08 A.M., a telephone interview was conducted with the Psychiatric Nurse Practitioner (PNP). The PNP stated staff told him that Resident 48 had delusions, hallucinations and violent behavior but he did not see the behaviors documented in Resident 48's chart. The PNP stated he did not observe the behaviors when he visited the resident and his assessment was based on verbal reports from staff. On 5/8/25 at 10:33 A.M., and interview was conducted with LN 5. LN 5 stated Resident 48 had episodes of restlessness, anxiety, and agitation but he had not observed behaviors such as delusions or hallucinations. LN 5 stated, I don't recall him ever hitting anybody or having violent behavior . On 5/8/25 at 11:25 A.M., a joint interview and record review was conducted with the DON. The DON stated there was no consistent documentation of resident having behaviors that would indicate schizophrenia. The DON stated, We should documented specific behaviors .make sure the physician has accurate data. We should have looked at [Resident 48's] behaviors and questioned whether this diagnosis is appropriate . The DON stated it was important to document specific behaviors, .so we don't give unnecessary drugs . On 5/8/25 at 1:27 P.M., a telephone interview was conducted with the Medical Director (MD). The MD stated his expectation was for Resident 48's behaviors to be documented, particularly because Resident 48 was taking antipsychotic medications. The MD stated it was important to document specific behaviors to ensure the medications were appropriate for the residents. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Psychotropic Medication Use, dated June 2021 indicated, .3. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to implement Registered Dietitian (RD 1) recommendations for one of three residents reviewed for nutrition (Resident 43). This failure had the potential for Resident 43 to not receive foods and supplements he preferred with his meals and snacks. Findings: Resident 43 was admitted to the facility on [DATE] with diagnoses to include brain cancer, per the facility's Admission Record. An observation and interview was conducted with Resident 43 on 5/5/25 at 3:15 P.M. Resident 43 was in bed, wearing jeans and a shirt. An end table was next to the bed, with a large bag of Cheetos and other chips on top. Resident 43 stated he had told people from the kitchen he did not like the foods he was getting. Resident 43 stated he received shakes with his meals, but the shakes were too sweet and he did not want them. Resident 43 stated he liked the frozen shakes he had tried, but he never got them. A record review was conducted on 5/8/25. Resident 43's Brief Interview for Mental Status (BIMS) score was 12 when assessed on 3/21/25, indicating moderately impaired cognition. Per a Dietary Profile note, authored by the Dietary Services Supervisor (DSS 1) and dated 3/17/25, Resident 43 had a fair appetite, and liked pudding, jello, milk and peanut butter and jelly sandwiches. Labs were drawn on 3/19/25. Albumin (a protein in the blood) level was 3 grams per deciliter (g/dL), indicated as low. Per a Nutrition Assessment, written by RD 1 and dated 3/23/25, Resident 43 had a so-so appetite, and RD 1 recommended allowing more foods on Resident 43's trays to encourage intake. RD 1 documented Resident 43 requested fried chicken and potato chips, as he loved crunchy foods. RD 1 documented those food items would not be allowed on Resident 43's current diet. RD 1 documented she had reviewed recent labs, and would add a protein powder to help increase Resident 43's low albumin level. Per an Interdisciplinary Team (IDT, a group of healthcare professionals) Progress Note, dated 3/25/25, Resident 43 had experienced weight loss. RD 1 and DSS 1 were present at the IDT. RD 1 documented the rationale for the weight loss was possibly due to inadequate intake at mealtimes. RD 1's documented plan to slow the weight loss was to add four ounce protein shakes with meals. (continued on next page)

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	055685	A. Building B. Wing	05/08/2025

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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per an IDT Progress Note, dated 5/2/25, Resident 43 had continued weight loss. RD 1 and DSS 1 were present at the IDT. RD 1 documented the weight loss was likely due to poor appetite. RD 1 documented Resident 43 was sick of the protein shakes, but was willing to try a frozen supplement, Magic Cup. RD 1 documented her plan to discontinue the protein shakes, add Magic Cups twice daily, add peanut butter to all meals, and update Resident 43's snack at night to his preferred tuna sandwich. Per a Nursing & Dietary Supervisor Report, authored by RD 1 and dated 5/2/25, the dietary recommendations were to be implemented within three days. An observation and interview with Resident 43 was conducted on 5/7/25 at 8:45 A.M. Resident 43 was sitting at the bedside, with his breakfast tray in front of him. The tray contained partially consumed hot cereal, a scrambled egg, milk, juice, peaches, and a vanilla protein shake. The protein shake was unopened. Resident 43 stated he still had not received the frozen Magic Cup. A concurrent interview and record review was conducted with DSS 1 on 5/7/25 at 3:30 P.M. DSS 1 stated he attended the IDT meetings, and when RD 1 made changes to residents' supplements or food preferences, she emailed the recommendations to him, then he entered the changes into the dietary software. DSS 1 opened his email, and identified RD 1's Nursing & Dietary Supervisor report, discontinuing the protein shakes, adding the Magic Cups, and adding peanut butter with all meals. DSS 1 stated the report was written 5/2/25, and he had received it on 5/5/25, but was busy and had not entered the changes into the computer. DSS 1 stated, Best case scenario, I should have entered them (into the computer) Monday 5/5, and we could have provided the Magic Cups and peanut butter by lunch time. This delay could cause continued weight loss and poor intake, we don't want that. A concurrent observation and interview with Resident 43 was conducted on 5/8/25 at 9 A.M. Resident 43 was seated on the edge of his bed, finishing his breakfast. Resident 43 had eaten about half of the foods on his breakfast tray. The tray had a four ounce vanilla protein shake on it, but the protein shake had not been opened. Resident 43 stated, See? It's not the frozen one. These are too sweet. I already told them I don't want these. A container of peanut butter was on the tray, and Resident 43 had consumed about half. An interview was conducted with RD 1 on 5/8/25 at 9:30 A.M. RD 1 stated she had emailed her recommendations for Resident 43 on Friday 5/2/25 at the end of the day. RD 1 stated the changes should have been entered into the computer on Monday 5/5/25 so Resident 43 would get his preferred Magic Cup, as well as the peanut butter for added calories and protein. RD 1 stated the facility policy allowed 72 hours to place dietary preferences into the computer, but they had exceeded the 72 hours. RD 1 stated she did not know why the food preferences were not provided to Resident 43 in a timely manner. An interview was conducted with the Administrator (ADM) on 5/8/25 at 11:14 A.M. Per the ADM, the expectation was for dietary staff to implement RD 1's recommendations as soon as possible. A facility policy, dated 2023 and titled Nutritional Screening/Assessments/Resident Care Planning, indicated, . All recommendations will be noted on a Facility Registered Dietitian Report .The FNS Director will complete the dietary recommendations within three days of receiving the Facility Registered Dietitian Report . A facility policy, dated 2023 and titled Food Preferences, indicated, .Updating of food preferences will be done as the resident's needs change .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to offer one of five residents (Resident 5) influenza (flu-annual season October through March) and pneumococcal (protects against serious lung infection referred to as pneumonia) vaccines as recommended by the Centers for Disease Control (CDC-a Federal agency responsible for preventing and controlling diseases), when reviewed for Immunization. This failure put Resident 5, and all other residents at risk of contracting and/or transmitting influenza and pneumococcal. Findings: Resident 5 was admitted to the facility on [DATE], with diagnoses which include dementia (progressive memory loss) and schizoaffective disorder, (a mental health condition where a person experiences symptoms of both schizophrenia and mood disorder), per the facility's Admission Record. Resident 5's had a Responsible Party (RP-a person legally assigned to make medical and financial decisions on the resident's behalf). The RP was a listed as the Public Conservator's office, (an entity appointed by the court system to act as a conservator for a person, who is unable to care for themselves due to mental illness). According to the copy of court documents in Resident 5's clinical record, conservatorship was established 3/18/24. On 5/7/25, Resident 5's clinical record was reviewed for verification of immunizations. There was no documented evidence Resident 5 or the RP had been offered the vaccine for influenza or pneumococcal, or that the risks and benefits had been explained verbally or in writing. An interview and record review was conducted with the Infection Control Nurse (ICN) on 5/7/25 at 3:01 P.M. The ICN stated all residents should be offered the influenza and pneumococcal vaccines upon admission. The ICP stated vaccinations were important because their residents were vulnerable and at risk of contracting the flu or pneumonia. The ICN stated all residents should be educated on the risk and benefits before accepting or declining the vaccines. The ICP stated they maintain consent forms in each residents' clinical record, indicating the vaccine was accepted or declined, and they had been informed of the risks and benefits. The ICN reviewed Resident 5's clinical record for immunizations. The ICN stated there was no evidence indicating Resident 5 was offered vaccinations. The ICN stated she recalled when Resident 5 was admitted , she was conserved by the County's Public Conservator's office. The ICN stated she asked the Social Services Director (SSD) to assist her with contacting the conservator's office to get permission for Resident 5's vaccinations. The ICN stated she never followed up with the SSD or Public Conservator's office, and the ball was dropped. The ICN stated since the conservatorship's office was never contacted for consent of vaccinations, Resident 5 was at risk for contracting influenza and pneumococcal. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 5/8/25 at 8:57 A.M. The DON stated she expected all residents to be offered the influenza and pneumococcal vaccines, with documentation of whether they had accepted or refused, along with the risk and benefits being explained to them. The DON stated by not offering the vaccines, all other residents' and staff were at risk of contracting infections from Resident 47, if infected. According to the facility's policy, titled Influenza Prevention and Control, dated September 2020, .The facility will follow infection control prevention and control policies and procedures to minimize the risk of Residents acquiring, transmitting or experiencing complications from influenza .B. Resident are offered an influenza immunization every year during flu season .C. The resident or resident's representative must give consent prior to receiving the vaccine. They can refuse the immunization-with such a refusal being noted in the Resident's medical record .D .i. The Resident or Resident representative was provided education regarding the risk and benefits and potential side effects . According to the facility's policy, titled Pneumococcal Disease Preventions, dated February 2021, .The facility will offer pneumococcal immunization to each Resident .A. Adults [AGE] years old or older .d. Before offering vaccine, each Resident (or Resident representative) must be given education regarding the benefits and potential side effects of the immunization .VI .v .Informed consent or refusal placed in the residents' medical record .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to offer one of five residents (Resident 5) a COVID-19 (a highly contagious virus caused by the SARS-CoV-2) vaccine recommended by the Centers for Disease Control (CDC-a Federal agency responsible for preventing and controlling diseases), when reviewed for Immunizations. This failure put Resident 5, and all other residents at risk of contracting and/or transmitting the COVID-19 virus. Findings: Resident 5 was admitted to the facility on [DATE], with diagnoses which include dementia (progressive memory loss) and schizoaffective disorder, (a mental health condition where a person experiences symptoms of both schizophrenia and mood disorder), per the facility's Admission Record. Resident 5 had a Responsible Party (RP-a person legally assigned to make medical and financially decisions on the resident's behalf). The RP was the Public Conservator's office, (an entity appointed by the court system to act as conservator/RP for a person, who is unable to care for themselves due to mental illness). According to a copy of the Resident 5's court document, conservatorship was established on 3/18/24. On 5/7/25, Resident 5's clinical record was reviewed for verification of immunization. There was no documentation Resident 5 or the RP had been offered the vaccine for COVID-19, or that the risks and benefits had been explained verbally or in writing. An interview and record review was conducted with the Infection Control Nurse (ICN) on 5/7/25 at 3:01 P.M. The ICN stated all residents should be offered the COVID-19 vaccine upon admission. The ICN stated vaccines were important because their residents were vulnerable and at risk of contracting COVID, if not vaccinated. The ICN stated all residents should be educated on the risk and benefits before accepting or declining the vaccines. The ICP stated they maintained consent forms in each resident's clinical record, indicating the vaccine was offered, that they accepted or declined, and were informed of the risks and benefits. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ICN reviewed Resident 5's clinical record for immunizations. The ICN stated there was no indication Resident 5 was offered a COVID-19 vaccination. The ICN stated she recalled when Resident 5 was admitted , she was under conservatorship by the County's Public Conservator's office. The ICN recalled asking the Social Services Director (SSD) to assist her by contacting the conservator's office, to get permission for Resident 5's vaccinations. The ICN stated she never followed up with the SSD or Public Conservator's office, and the ball was dropped. The ICN stated since there was no documented evidence the conservatorship's office was ever contacted for consent of Resident 5's COVID-19 vaccination this put Resident 5 was at risk of possibly contracting COVID-19. An interview was conducted with the Director of Nursing (DON) on 5/8/25 at 8:57 A.M. The DON stated she expected all residents' to be offered the COVID-19 vaccine, with documentation whether they had accepted or refused, along with the risk and benefits being explained to them. The DON stated by not offering the vaccine, all other residents and staff were at risk of contracting COVID-19 from Resident 5, if infected. According to the facility's policy, titled COVID-19 Vaccination Program, dated March 2022, .The facility will offer SARS-CoV-2 vaccinations (including additional and booster doses) to all Residents. They will be encouraged but not required to be vaccinated or boosted . II. Preparation for a Vaccine Administration Clinic: .D. Send educational material provided by the vaccine provider to residents, their families, responsible parties, legal representative .E. Obtain general consent .