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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055795	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place San Diego	1350 N. Euclid Avenue San Diego, CA 92105

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure one of two sampled residents (1) who had a colostomy (a surgical procedure that creates an opening in the large intestine, or colon, through the abdominal wall for the stool to pass into a bag) received the necessary care and treatment when the facility did not develop a baseline care plan (sufficient information to provide care properly), get a physician order, and treatments provided to Resident 1 was documented in the resident's treatment administration record (TAR). These failures had the potential for Resident 1 not to receive colostomy care timely as prescribed by the physician and not receive consistent care from the licensed nurses during colostomy bag changes. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses that included colostomy status and was transferred to the hospital on 8/4/24 per the Admission Record. A review of Resident 1's medical record was conducted. There was no documented evidence of Resident 1's baseline care plan for the colostomy care and treatment. Per the Order Recap Report, dated 7/29/24, Resident 1 had a physician's order to change Resident 1's colostomy bag as needed (PRN). There was no documented evidence of how to change the colostomy and monitor the site for infection. A review of Resident 1's Treatment Administration Record (TAR), from 7/25/24 through 8/4/24, Licensed Nurse (LN) 3 changed Resident 1's colostomy bag on 8/2/24. There was no documentation for monitoring skin condition or indication that the colostomy bag was changed on multiple occasions. On 8/22/24 at 11:15 A.M., a joint interview and record review was conducted with the Treatment Nurse (TN). The TN stated she changed Resident 1's colostomy bag daily, sometimes twice during an eight-hour shift. TN further stated she tried different adhesives and supports, like a belt and abdominal binder, to hold the colostomy. TN stated she should have signed the TAR every time she did the treatment and gotten the physician's order. TN further said there was no baseline care plan for Resident 1 created on admission, and should have. (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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:45 A.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated the baseline care plan should have been developed for Resident 1, but it was not. The DON further stated the TAR should reflect the care provided to Resident 1, and the LNs should have signed the TAR when they changed Resident 1's colostomy bag. The DON stated that for any changes in the resident's care, the physician should have been notified and updated the care plan and TAR. Per the facility's policy and procedure, dated 11/18, titled Comprehensive Person-Centered Care Planning, . The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission . Per the facility's policy and procedure, dated 4/24/19, Colostomy and Iileostomy Care - General. [the] Stoma and surrounding skin will be monitored for irritation with routine care .Document treatment done and any pertinent nursing observation in the resident's medical record.