| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055795 | A. Building<br>B. Wing | 12/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brighton Place San Diego | 1350 N. Euclid Avenue<br>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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610<br><br>Based on interview, and record review, the facility staff failed to monitor and document urine output (UO) per the facility's policy, for one of three sampled residents (Resident 2) with a urinary catheter (a tube inserted into the bladder to aid in urine flow).<br><br>This failure had the potential for Resident 2 to have urinary retention and developed urinary tract infection (UTI).<br><br>Findings:<br><br>On 11/15/24, the Department received a complaint related to Resident Assessment.<br><br>On 11/26/24, an unannounced visit to the facility was conducted.<br><br>Resident 2 was admitted to the facility on [DATE], with diagnoses which included fracture of the cervical bones and needed assistance with personal care, per the facility's Admission Record.<br><br>On 11/26/24, a review of Resident 2's minimum data set (MDS - a federally mandated assessment tool), dated 11/5/24, indicated Resident 2 had a urinary catheter on admission.<br><br>On 11/26/24 at 1:20 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 2 was bedbound and had a urinary catheter. CNA 1 stated the staff did not measure the urine output of Resident 2's urinary catheter. CNA 1 stated the documentation they (CNAs) indicate in Resident 2's clinical record was either continent or incontinent and there was no measurement of urine output. CNA 1 stated, No one told us to check the urine output.<br><br>On 11/26/24 at 3:45 P.M., a joint review of Resident 2's clinical record and an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 2 had a urinary catheter because of his dysfunctional bladder. LN 1 stated the policy was to monitor residents' urine output when they have a urinary catheter. LN 1 stated she did not see documentation of Resident 2's UO in his clinical record. LN 1 stated there was no indication if Resident 2 had low UO.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/26/24 at 4:11 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the policy was to monitor the urinary output of the residents with urinary catheter and staff should have documented residents' UO in the residents' clinical record. The DON stated when CNAs emptied the urinary catheter, the CNAs should be checking the residents' UO and documented in the residents' clinical record to make sure the residents were voiding.<br><br>A review of the facility's policy titled, Indwelling Catheter, revised 9/1/14, indicated, Purpose: To relieve bladder distention .to maintain constant urinary drainage .III. Catheter Care .C .Output Recording will take place in accordance with .Intake and Output Recording . |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610<br><br>Based on interview, and record review, the facility failed to ensure proper medication administration for one of three sampled residents (Resident 1), when an anti-rejection medication (are medicines that keep organ transplants from being attacked by the immune system) was not administered per the physician's order.<br><br>As a result, there was an increased risk for Resident 1's transplanted organ to be rejected by her body.<br><br>Findings:<br><br>On 11/12/24, the Department received a complaint related to quality of care.<br><br>On 11/26/24, an unannounced visit to the facility was conducted.<br><br>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included liver transplant.<br><br>A review of Resident 1's physician order dated 9/27/24 indicated the following order:<br><br>- Tacrolimus (anti-rejection medication) 1 mg 3 caps (3 mgs total) twice a day (given at 8 A.M. and 5 P.M.) via gastrostomy tube (Gtube, a surgical opening fitted with a device to allow feedings and medications to be administered directly to the stomach).<br><br>On 11/26/24 at 11:40 A.M., a joint review of Resident 1's medication administration record (MAR, used to document medications taken by each patient) and an interview with Licensed Nurse (LN) 1 was conducted. The MAR for September 2024 through October 2024 was reviewed with LN 1.<br><br>The MAR for tacrolimus for Resident 1 indicated the following entries:<br><br>- September 2024<br><br>9/27/24 for 5 P.M. dose - no medication on hand.<br><br>9/29/24 for 8 A.M. dose - no medication on hand.<br><br>- October 2024<br><br>10/12/24 for 5 P.M. dose - medication pending delivery.<br><br>10/13/24 for 8 A.M. dose - on order, follow up in pharmacy, not available.<br><br>10/15/24 for 5 P.M. dose - there were no notes.<br><br>10/22/24 for 5 P.M. dose - there were no notes.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LN 1 stated there were days which the LNs assigned to Resident 1 did not make an entry on why Resident 1 did not receive her tacrolimus.<br><br>On 11/26/24 at 12:45 P.M., an interview with LN 2 was conducted. LN 2 stated Resident 1 had a tacrolimus order on 9/27/24 after her medical appointment. LN 2 stated the facility did not have the medication on hand.<br><br>On 11/26/24 at 4L11 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated she verified with the pharmacy and stated there were tacrolimus medications supplied to the facility. The DON stated, there should be no missed treatment to prevent organ rejection, especially if the medication was available. The DON stated it was very important for the resident.<br><br>A review of the facility's policy titled Telephone Orders for Medication, revised 1/2012, indicated, .Policy, I. The facility will administer medications .ordered by an Attending Physician and/or a Nurse Practitioner . |