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	08/13/2025

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 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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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. In addition, Resident 1 did not have a nurse's note, indicting when she left the facility for discharge, with whom she left, where she was going, and how she was being transported. These failures had the potential for residents to experience increased anxiety, when last minute discharges were conducted, with no ability to appeal the discharge, and the reader was uninformed of where the resident was transported to and when. Finding:An unannounced visit was made to the facility on 8/13/25, in response to a complaint involving a discharge.1. Resident 1 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (progressive memory loss), per the facility's admission Record. On 8/13/25, Resident 1's clinical record was reviewed. According to the facility's Social Service notes, dated 1/12/25 at 5:31 P.M., Resident 1 was going to be discharged to (name of facility), for supervised care in a secured unit (when residents are unable to leave the unit because of cognitive impairment, such as dementia, who require supervision and a safe environment). There was no documented evidence that nursing staff documented when resident left the faciity on 1/13/25, with whom she left, where she was going, or how she was getting there. According to the facility's Discharge Planning Review, dated 1/13/25, Resident 1 was being discharged as a lateral transfer to another facility for continuum of care. The name of the facility she was being transferred to was not documented.There was no documented evidence that a written Notice of Transfer/Discharge was provided to Resident 1 or her family, prior to discharge.2. Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's admission Record.On 8/13/25, Resident 2' clinical record was reviewed. According to the facility's Discharge Planning Review, dated 6/12/25, Resident 2's health had improved and was being discharged to a lower level of care. According to the facility's Discharge Summary note, dated 6/12/25 at 11:06 A.M., Resident 2 was transported to (name of facility) Board and Care by her son, with all belongings and medications.There was no documented evidence that a written Notice of Transfer/Discharge was provided to Resident 2 or her family, prior to discharge.3. Resident 3 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (a progressive disease in which affects brain functioning), per the facility's admission Record. On 8/13/25, Resident 3's clinical record was reviewed. According to the facility's Social Service notes, dated 7/11/25 at 3:20 P.M., Resident 3 was discharged to Board and Care (name of facility).According to the facility's Discharge Planning Review, dated 7/11/25, Resident 3 was being discharged for a lower level of care. There was no documented evidence that a written Notice of Transfer/Discharge was provided to Resident 3 or the family, prior to discharge. An interview was conducted with Licensed Nurse 1 (LN 1) on 8/13/25 at 11 A.M. LN 1 stated written Notice of Transfer/Discharges were provided to the residents and their families by the Social Service Director (SSD). LN 1 stated Notices of Transfers/Discharges were important, so the residents knew what was coming and that staff were making preparations for the discharge. LN 1 stated if the Notice was not provided, it could increase anxiety for the resident before discharge, because they did not have time to prepare and ask questions. LN 1 stated without a Notice of Discharge being provided, it also eliminated the resident's right to appeal the discharge, because they were never informed they had that right. An interview and record review was conducted with LN 2 on 8/13/25 at 11:05 A.M. LN 2 stated written Notice of Transfer/Discharge were given to the residents and families within 30 days prior to discharge. LN 2 stated the Notice of Transfer/discharge was important, so residents and families were aware the discharge was pending and they could appeal, provide input, and make choices about where they were being discharged to. LN 2 stated Notice of Transfer/Discharge also decreased anxiety, so planning and preparation for discharge could be provided. LN 2 reviewed Resident 1, 2, and 3's clinical record and could not find any documentation a written Notice of Transfer/Discharge was ever provided. LN 2 stated the SSD was responsible for providing the Notice of Transfer/Discharge to the residents and their families.The SSD was unavailable on 8/13/25 for an interview.An interview and record review was conducted with the Director of Nursing (DON) on 8/13/ 25 at 11:20 A.M. The DON reviewed Resident 1's nurses note and stated there was no discharge documentation related to when the residents left the facility or where she was transported to. The DON stated a nurse's note was required for every discharge of when, where, how and with who. The DON stated this was a nursing standard or practice and was not followed when Resident 1 was discharged

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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 a person -centered care plan related to discharge, during the stay for two of three residents (Resident 1 and Resident 3), reviewed for discharges. This 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 8/13/25, in response to a complaint involving a discharge.1. Resident 1 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (progressive memory loss), per the facility's admission Record.On 8/13/25, Resident 1's clinical record was reviewed.According to the facility's Social Service notes, dated 1/12/25 at 5:31 P.M., Resident 1 was going to be discharged to (name of facility), for supervised care in a secured unit (when residents are unable to leave the unit because of cognitive impairment, such as dementia, who require supervision and a safe environment).According to the facility's Discharge Planning Review, dated 1/13/25, Resident 1 was being discharged as a lateral transfer to another facility for continuum of care. The name of the facility she was being transferred to was not documented. There was no documented evidence that a discharge care plan had been developed or implemented.2. Resident 3 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (a progressive disease in which the brain functioning is affected), per the facility's admission Record.On 8/13/25, Resident 3's clinical record was reviewed.According to the facility's Social Service notes, dated 7/11/25 at 3:20 P.M., Resident 3 was discharged to Board and Care (name of facility).According to the facility's Discharge Planning Review, dated 7/11/25, Resident 3 was being discharged for a lower level of care.There was no documented evidence that a discharge care plan had been developed or implemented. An interview was conducted with Licensed Nurse 1 (LN 1) on 8/1/25 at 11 A.M. LN 1 stated discharge care plans should be developed upon admission, so all staff were aware of the residents' discharge wishes. LN 1 stated the discharge care plans were also important, because staff should be working towards a common goal of getting the residents ready for discharge, to decrease anxiety for the them and their families. An interview and record review was conducted with LN 2 on 8/13/25 at 11:05 A.M. LN 2 stated discharge care plans were important, so staff were aware of the residents' goals for discharging. LN 2 stated if a discharge care plan was not created, then there was no collaborated goal and organization of staff honoring the resident's wishes to discharge. LN 2 reviewed Resident 1 and Resident 3's clinical records and stated she could not locate a discharge care plan for either resident, which could have harmed their actual discharge, due to last minute planning.An interview was conducted with the Director of Nursing DON. The DON stated individual discharge care plans should be developed and implemented at the time of admission. The DON stated discharge care plans were important for staff communication, to know what the residents' plans were for an organized, goal-oriented, discharge. The DON stated by Resident 1 and Resident 3, not having a discharge care plan, there was potential the for harm because staff were not working towards the resident's goal of discharging. According to the facility's policy, titled Comprehensive Person-Centered Care Planning, August 2023, The facility will provide person-centered, comprehensive, and interdisciplinary care that reflets best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.