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	09/02/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the infection control program practices when: 1. The facility did not report COVID (infectious disease) outbreak to the California Department of Public Health Licensing and Certification (CDPH L&C, program which is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians).2. The resident's family member was not educated on infection control and the use of personal protective equipment (PPE, use of gown, gloves and mask to be worn or held by an individual for protection), for one of two residents (1) on contact precautions (used for infections, diseases, or germs that are spread by touching the patient or items in the room). This failure had the potential to transmit infections to residents, staff, and visitors.Findings: 1.On 8/19/25, the Department received a report which indicated there was a COVID outbreak in the facility with three residents tested positive. On 9/2/25, an unannounced onsite was conducted to the facility. On 9/2/25 at 2:03 P.M., a joint review of residents' clinical record and an interview was conducted with the Director of Nursing (DON). The DON stated they had 10 residents who were tested positive from 8/18/25 to 8/26/25. The DON stated there was one Certified Nursing Assistant (CNA) who also tested positive. The DON stated the Infection Preventionist (IP) informed him the outbreak was reported to CDPH. The DON stated he did not follow up. The DON stated he should have followed up on to whom the outbreak was reported to be in compliance with the regulation and protect the residents and the community. On 9/2/25 at 2:28 P.M., an interview was conducted with the Administrator (ADM). The ADM stated she should have clarified and verified it was reported to CDPH L&C. The ADM stated, It was reported to the local county. A review of the facility's policy titled Respiratory Virus Prevention and Control Plan, revised 3/31/25, indicated, .OUTBREAK DEFINITIONS, REPORTING, AND DURATION OF OUTBREAK CONTROL MEASURES; COVID-19: Residents: 2 cases of probable or confirmed COVID-19 among residents. 2. Resident 10 was admitted to the facility on [DATE], per the facility's admission Record. On 9/2/25 at 2:07 P.M., an observation of Resident 10 was conducted in his room with the presence of the DON and Licensed Nurse (LN) 1. There was a contact precaution (intended to prevent transmission of infectious agents and microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment) sign by the resident's door. There were three residents in the room. Resident 10 laid in bed with a family member (FM) at bedside. Resident 10's FM was assisting Resident 10 during meals. Resident 10's FM did not wear PPE while assisting Resident 10. At this time, the DON prompted LN 1, LN 1 then asked Resident 10's FM why she was not wearing PPE, Resident 10's FM stated she was allergic to the gown and that she was not going to leave. On 9/2/25 at 3:21 P.M., an interview was conducted with LN 1. LN 1 stated Resident 10's FM was aware of the facility's policy. LN 1 stated it was important for the visitors to comply with putting on and removing the PPE to prevent spread of infection. LN 1 stated Resident 10's FM did not report allergic reactions to the use of PPE until today (9/2/25). On 9/2/25 at 3:25 P.M., a joint review of the facility's infection log and an interview was conducted with the Director of Nursing (DON). The DON stated visitors were to wear PPE when entering the residents on contact precautions to protect themselves and prevent the spread of infection to others. A review of the facility's policy titled Respiratory Virus Prevention and Control Plan, revised 3/31/25, indicated, .Don gowns and gloves after performing hand hygiene upon entry into the room or entry into a bedspace and doff gowns and gloves followed by hand hygiene upon exiting the room or leaving a bedspace.