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	01/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation and interview, the facility failed to ensure that resident bathrooms were maintained in a sanitary manner for four of 16 sampled bathrooms (1 and 2). As a result, there was an increased risk of residents feeling uncomfortable using their bathroom. Findings: 1. Per the facility's Admission Record, Resident 144 was admitted to the facility on [DATE]. On 1/12/25 at 9 A.M., an interview was conducted with Resident 144. Resident 144 stated, Bathroom [ROOM NUMBER] had feces on the walls and at the base of the toilet. Resident 144 further stated, the feces had been there since she admitted to the facility (48 days prior), and the bathroom had never been cleaned in that time. Per the facility's Admission Record, Resident 56 was admitted to the facility on [DATE]. On 1/12/25 at 9:16 A.M., an interview was conducted with Resident 56. Resident 56 stated, Bathroom [ROOM NUMBER] was dirty, and it looked like someone, had an explosion in the bathroom. Resident 56 further stated, there had been feces around the toilet for more than a week. On 1/12/25 at 9:20 A.M., an observation was conducted of Bathroom [ROOM NUMBER]. There was brown material at the base of the toilet, streaks of a brown liquid that had ran down the wall behind the toilet, and the back of the toilet. 2. On 1/12/25 at 9:35 A.M., an observation was conducted of Bathroom [ROOM NUMBER]. There was brown material at the base of the toilet where the bolt secured it to the floor. Per the facility's Admission Record, Resident 60 was admitted to the facility on [DATE]. On 1/12/25 at 9:47 A.M., an interview was conducted with Resident 60. Resident 60 stated, that Bathroom [ROOM NUMBER] should have been cleaner. Resident 60 further stated, that he thought about the cleanliness of the bathroom while he was using it, but he tried not to let it bother him. Per the facility's Admission Record, Resident 55 was admitted to the facility on [DATE]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/25 at 10:42 A.M., an interview was conducted with Resident 55. Resident 55 stated that Bathroom [ROOM NUMBER] was not clean enough. On 1/15/25 at 7:49 A.M., a concurrent observation and interview was conducted with the Housekeeping Supervisor (HKS). The referenced brown spots in Bathrooms [ROOM NUMBERS] were still there from the observation on 1/12/25. The HKS stated, that Bathrooms [ROOM NUMBERS] should not have still been soiled, and the brown spots should have been cleaned in the last three days. Per the facility's policy, titled Resident Rooms and Environment, revised 1/1/12, .The Facility provides residents with a safe, clean, comfortable, and homelike environment . Per the facility's policy, titled Housekeeping - Resident Rooms, revised 9/16, .The Housekeeping Department coordinates the daily cleaning of all resident rooms .The restroom is cleaned thoroughly with disinfectants .

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interviews, and record reviews, the facility failed to send a copy of the notice to transfer/discharge form to the Ombudsman office for two of six reviewed residents (Resident 6 and 72) that required immediate transfer to an acute care hospital for urgent needs. These failures resulted in a lack of resident discharge notification to the State Long Term Care (LTC) Ombudsman to advocate and assist the residents (Resident 6 and 72) with appeal rights as needed. Findings: 1. A review of Resident 6's Admission Record indicated Resident 6 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain). On 1/12/25 at 3:46 P.M., a record review was conducted. Resident 6 had a change of condition (COC) progress note dated 12/11/24 that indicated Resident 6 was transferred to acute care related to an abnormal heart rate (HR) of 35 with notification given to the Medical Doctor (MD) and son. On 1/14/25 at 9:06 A.M., an interview was conducted with the Social Services Director (SSD). The SSD stated that she was responsible to notify the LTC Ombudsman when they were discharged home or transferred to another LTC facility. The SSD stated for acute hospital transfers the nurses do it. On 1/14/25 at 9:08 A.M., an interview was conducted with the Medical Records Director (MRD). The MRD stated at her previous facility as an MRD she used to send out a copy of transfer/discharge notice to the LTC Ombudsman (OMB). The MRD stated that she questioned the current facility if sending out a copy of transfer/discharge notice to the LTC OMB was part of her workload and stated nobody got back to me in regards to doing that but I'm willing to do that here. The MRD stated it's important to send that information to the ombudsman so that they are aware of residents being transferred to the hospital and to follow up to advocate and to appeal when needed. On 1/14/25 at 9:13 A.M., a telephone interview was conducted with the OMB. The OMB stated she had never received a copy of transfer/discharge notice for residents transferred to acute care hospitals. On 1/15/25 at 7:40 A.M., a joint interview and record review was conducted with LN 2, at the nursing station. LN 2 stated that Resident 6 was sent out to the emergency room (ER) per the COC (e-interact) document on 12/11/24. LN 2 stated that the MD and son were notified but was unable to find documentation or records that indicated that the LTC Ombudsman was notified. LN 2 stated she was not aware that they needed to contact the OMB and stated that licensed nurses (LN)s usually only notified the MD, family members, and/or their responsible parties (RP). (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:39 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that it was his expectations to follow the regulations for transfer/discharge notifications and that the LTC OMB should be notified for hospitalization transfers. The DON stated it was important for the OMB to be notified because they were the patient advocates and in case they want to get more information to appeal, it is their [residents] right. A review of the facility's policy and procedure titled NOTICE OF TRANSFER AND DISCHARGE revised October 2017, indicated When a transfer or discharge is initiated by the facility, the facility will provide the resident, responsible party, and the Ombudsman with a Notice of Transfer and Discharge 30 days prior to the transfer or discharge .C. The resident's urgent medical needs that cannot be met in the facility and requires immediate transfer; and D. The health of individuals in the facility would otherwise be endangered; In these cases, the notice will be given as soon as practicable prior to discharge . 2. A review of Resident 72's Admission Record indicated Resident 72 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral Infarction (type of stroke, when the part of the brain tissues dies and loss of blood flow to a part of the brain). On 1/14/25 at 8:59 A.M., a joint interview and record review was conducted with Licenced Nurse (LN) 4, in the nursing station. LN 4 stated that Resident 72 was transferred to an acute hospital on 12/26/24 for low hemoglobin (HGB- is a protein in red blood cells that carries oxygen throughout the body. When hemoglobin levels are low, the body's tissues don't get enough oxygen and can't function properly) labs. LN 4 stated that according to the document titled SBAR (Situation, Background, Appearance, Review) Communication Form that the Nurse Practitioner (NP) and family members were notified along with Hospice (End of life medical care). LN 4 stated that he was unable to find documentation that the Long Term Care (LTC) Ombudsman (OMB) was notified. LN 4 stated as part of the clinical role with transfers that the LNs were responsible for contacting the Medical Doctor (MD) or NP and then call the family per face sheet. LN 4 stated he was not aware that the LTC OMB needed to be notified and sent a copy of transfer/discharge for hospital transfers. On 1/14/25 at 9:06 A.M., an interview was conducted with the Social Services Director (SSD). The SSD stated that she was responsible to notify the LTC OMB when they are discharged home or transferred to another LTC facility. The SSD stated, for acute hospital transfers the nurses do it. On 1/14/25 at 9:08 A.M., an interview was conducted with the Medical Records Director (MRD). The MRD stated at her previous facility as an MRD she used to send out a copy of transfer/discharge notice to the LTC Ombudsman (OMB). The MRD stated that she questioned the current facility if sending out a copy of transfer/discharge notice to the LTC OMB was part of her workload and stated nobody got back to me in regards to doing that but I'm willing to do that here. The MRD stated it's important to send that information to the ombudsman so that they are aware of residents being transferred to the hospital and to follow up to advocate and to appeal when needed. On 1/14/25 at 9:13 A.M., a telephone interview was conducted with the Ombudsman (OMB). The Ombudsman stated she had never received a copy of transfer/discharge notice for residents transferred to acute care hospitals. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:19 A.M., an interview was conducted with the Director of Nursing (DON), in the DON's office. The DON stated it was his expectations that we send the notice of transfer/discharge form to the Ombudsman from here on out. The DON stated it should be part of the Medical Records Director (MRD) to be responsible to send that information to the Ombudsman according to regulations. The DON stated it was important that the Ombudsman is informed and alerted because they are the patient advocate for the residents for their right to appeal and to be informed of the residents whereabouts. A review of the facility's policy and procedure titled NOTICE OF TRANSFER AND DISCHARGE revised October 2017, indicated When a transfer or discharge is initiated by the facility, the facility will provide the resident, responsible party, and the Ombudsman with a Notice of Transfer and Discharge 30 days prior to the transfer or discharge .C. The resident's urgent medical needs that cannot be met in the facility and requires immediate transfer; and D. The health of individuals in the facility would otherwise be endangered; In these cases, the notice will be given as soon as practicable prior to discharge .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 47956 Based on observation, interview, and record review the facility failed to complete a comprehensive elopement assessment for one of six sampled residents (Resident 198). As a result, Resident 198 eloped from the facility. Findings A review of Resident 198's Admission Record dated 12/27/24, indicated that Resident 198 had a diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During an observation on 1/12/25 at 10:50 A.M. Resident 198 was observed ambulating without assistance or assistive devices in the main hallway of the building. Resident 198 was accompanied by a facility staff member. During an observation on 1/13/25 at 8:50 A.M. The location of Resident 198's elopement was identified and found to provide access to Highway on and off ramps. During an interview on 1/13/25 at 8:50 A.M. with the Administrator (ADM). The ADM stated on 1/2/25, Resident 198 came out of the door, set off the alarm, went past two residents, climbed over the fence, and went toward the church. The staff followed and Resident 198 was found at the church and returned to the facility. We are working on having her transferred to another facility . that should happen today. During an interview on 1/13/25 at 9 A.M. with Resident 198. Resident 198 stated the nurse was making me upset, and I wanted to get away. I was going to the bus stop, but I saw people running after me and I didn't want to get anyone in trouble. The bus came by, and I just waved it off, I wasn't going to get on it. A record a review was conducted on 1/15/25 with the following: - The Psychiatric Consultation Note dated 12/20/2024, the note states She (Resident 198) is forgetful and has attempts to wander off by herself. - The Psychiatric Consultation Follow up Note dated 12/24/2024, the note stated .needs redirection as she (Resident 198) wanders off . - The Hospitalist Progress note dated 12/27/2024, the note stated .given the patients (Resident 198) elopement risk . (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 9:49 A.M. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated we can tell by their behavior, pacing, irritable, or they may verbalize that they don't want to be here. LVN 2 further stated we assess the triggers, get social services involved, redirect to why they are here, and get families involved. LVN 2 stated If a resident does elope, we notify all staff, family, and the Police Department. We do send out staff to look for the resident. LVN 2 further stated, we have a binder for elopement and wander risk residents, but it has not been updated since June. Depending on their cognition level, a resident could get hit by a car, or they could get dehydrated. During an interview on 01/15/25 at 10:10 A.M. with the Director of Nursing (DON), the DON stated we do an assessment on admission, if there is a diagnosis of dementia we reach out to RP (Responsible Party) to get authorization for a wander guard [a safety bracelet that alarms when triggered], contact the doctor and get the order. The DON further stated staff is notified in the morning meeting about wander risk residents and as identified during the shift. If they get off the premises, we report it public health, Ombudsman, law enforecement. The DON concluded If a resident does successfully elope there is the possibility of injury or missing medications.

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48263

Based on observations, interviews, and record reviews, the facility failed to accurately code the Minimum Data Set (MDS-a federally mandated resident assessment tool) according to the Resident Assessment Instrument (RAI-instructions for MDS) manual and the facility's MDS policies and procedures for three of 29 sampled residents (Resident 72, 29, and 23) when:

1. Resident 72's fall incident was not accurately coded.

2. Resident 29's fall incident was not accurately coded.

3. Resident 23's pneumonia diagnosis was coded as active without supporting documentation.

As a result, the facility sent Residents (Resident 72, 29, and 23) MDS's to the federal database with inaccurate health status.

Findings:

1. A review of Resident 72's Admission Record indicated Resident 72 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral Infarction (type of stroke, when the part of the brain tissues dies and loss of blood flow to the brain).

A record review of Resident 72's MDS dated [DATE] indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 72 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits.

On 1/13/25 at 7:32 A.M., a record review was conducted on Resident 72's clinical chart. Resident 72's progress note dated 10/27/24, indicated an unwitnessed fall happened while attempting to self-toilet.

On 1/13/25 at 10:03 A.M., a joint record review and interview was conducted with the MDS Nurse (MDSN), in the MDS office. The MDSN stated the progress note on 10/27/24 at 1915 (8:15 P.M.) indicated, resident fell assisted back to bed due to attempting to self-toilet. The MDSN stated Resident 72 did not have an injury of indication of head injury from the fall. The MDSN reviewed the quarterly MDS dated [DATE] quarterly assessment and stated she did not capture the fall on section J1800 and did not accurately capture the number of falls for no injury on section J1900 of the MDS. The MDSN stated since the fall happened on 10/27/24 it would not be captured on the previous MDS dated [DATE] but should have been accurately coded on the MDS dated [DATE] because of the fall incident timeline. The MDSN stated it was important to capture an accurate assessment because the MDS is transmitted to the federal database and it was important that it reflected Resident 72's current health status which also triggers the quality measures (QM) of the facility. The MDSN stated that the MDS drives the whole assessment for care coordination and also the plan of care for the resident and what interventions we need to monitor. I have to modify the MDS and re-transmit.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:04 A.M., and interview was conducted with the Director of Nursing (DON), in the DON's office. The DON stated it was important for the MDSN to accurately code Resident 72's fall incident to capture Resident 72's current health status. The DON stated the MDS drives the plan for the residents and the information sent by MDS is transmitted to the federal database. The DON's expectations was for the MDS to be accurately coded. A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page J-34-35) Section J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent .Code 1, yes: if the resident has fallen since the last assessment Section J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent .A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury . 50175 2. Resident 29 was admitted on [DATE] with diagnoses including degenerative disease of the nervous system (a condition that cause nerve cells to die causing mental and physical decline) per the Admission Record. A review of Resident 29's record was conducted on 1/13/25. A progress note dated 5/28/24 at 11:27 P.M. indicated Resident 29 was found on the floor laying on the right side. A progress note dated 5/28/24 at 11:36 P.M. indicated the fall was not witnessed and the fall occurred in Resident 29's room. A joint interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 1/14/25 at 11:00 A.M. The MDSN stated the MDS assessment, dated 8/1/24, was the assessment completed after Resident 29's fall. The MDSN stated the MDS assessment for 8/1/24 did not reflect that Resident 29 had a fall prior to 8/1/24. The MDSN stated the MDS assessment should be accurate so everyone knew what happened to the patient. An interview with the Director of Nursing (DON) was conducted on 1/15/25 at 9:52 A.M. The DON stated the MDSN should have updated the MDS assessment to reflect Resident 29's fall because the MDS assessment helped guide patient care. A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2024, (Page J-34-35) Section J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent .Code 1, yes: if the resident has fallen since the last assessment Section J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent .A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury . 39448 3. Per the facility's Admission Record, Resident 23 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD - a lung disease). Per the agency's MDS' dated 2/22/24, 5/22/24, 8/21/24, and 11/19/24, under Section I - Active Diagnoses, Resident 23's Primary Medical Condition was Pneumonia (a lung infection). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 2:23 P.M., a concurrent interview and record review was conducted with the MDSN. The MDSN stated, Resident 23 was diagnosed with pneumonia on 12/18/23. The MDSN further stated, Resident 23's pneumonia resolved, and it should not have been documented on the MDS on 2/22/24, 5/22/24, 8/21/24, or 11/19/24. Per the facility's policy, titled RAI (Resident Assessment Instrument) Process, revised 10/4/16, .Purpose .To provide resident-assessments that accurately depict and identify resident-specific issues . Per the facility's policy, titled Diagnosis List, revised 4/8/16, .Ensure that accurate .coding is assigned .When a diagnosis is resolved, the Diagnosis List form will indicate the date the diagnosis was resolved .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on interview and record review, the facility failed to ensure the Preadmission Screening Resident Review (PASRR, a federal requirement to help ensure that individuals were not inappropriately placed in nursing homes) was accurate for one of six sampled residents (Resident 69). This failure had the potential for Resident 69's mental health needs to be unmet. Findings: Resident 69 was admitted to the facility on [DATE] with diagnoses including psychosis (a mental illness involving hallucinations and delusions) and depression (a mental illness involving long periods of being sad or hopeless) per the Admission Record. A review of Resident 69's medical record was conducted on 1/12/25. Resident 69 was discharged from a hospital prior to his admission to the facility with medications including aripiprazole (an antipsychotic medication) to start on 12/15/24. A review of Resident 69's physician's orders for January 2025 indicated a current order for aripiprazole. An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 1/14/25 at 1:05 P.M. The MDSN stated Resident 69 has a diagnosis of psychosis and was taking a psychotropic medication (an antipsychotic). The MDSN stated the PASRR screening dated 12/5/24 indicated that Resident 69 did not have a serious mental illness like psychosis and did not indicate Resident 69 was on psychotropic medications. The MDSN stated the PASRR was not accurate. The MDSN stated there were no other PASRRs completed during Resident 69's admission. The MDSN stated the PASRR should have been corrected so Resident 69 would get the care he needs. An interview with the Director of Nursing (DON) was conducted on 1/15/25 at 10:06 A.M. The DON stated the PASRR should have reflected that Resident 69 was on a psychotropic medication and that Resident 69 had psychosis. The DON stated the PASRR should have been reviewed and corrected so Resident 69 would get the appropriate mental health care. A review of the facility's policy titled Admission Screening Resident Review (PASRR), revised 9/1/23, indicated, .will be responsible to assess and ensure updates to the PASRR are completed per MDS (Minimum Data Set, an assessment tool) guidelines .

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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** 48263 Based on observations, interviews, and record reviews, the facility failed to implement or develop a person centered care plan for two of 29 sampled residents (Resident 84, 9, 198) when: 1. Resident 84's nutritional care plan did not address nutritional preferences and dislikes. 2. Resident 9's care plan did not include a Hospice care plan. 3. Resident 198's care plan did not indicate a person-centered approach to prevent future wandering/elopement while at the facility. As a result, Resident 84's and Resident 9's plan of care was not personalized that promotes or maintains their highest practicable physical, mental, and psychosocial well-being. Cross-Reference F803 Findings: 1. A review of Resident 84's Admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses which included a history of Chronic Kidney Disease Stage four (CKD stage 4- kidneys are moderately or severely damaged and are not properly filtering waste from your blood). A record review of Resident 84's minimum data set (MDS - a federally mandated resident assessment tool) dated 10/28/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 84 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 1/12/25 at 10:19 A.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 stated that he was a kidney patient and at the border of not having to need dialysis. Resident 84 stated that the facility was consistently serving meals that were not good for him because he was a kidney patient. Resident 84 further stated they [the facility staff] feed me trash I cannot eat such as fruits like oranges that are high in potassium (a mineral that is essential to body functions but an excess of potassium can build up with kidney disease due to the kidney's unable to remove the mineral from the body that could have harmful health effects). On 1/12/25 at 1:22 P.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 had a meal tray on his bedside table that included green peas, mashed potatoes, a bitten slice of chicken and oranges on the side. Resident 84 stated he did not like green peas, potatoes and could not eat the oranges because it is not good for my kidneys and it's on my dislikes list. Resident 84's meal tray card indicated, Dislikes .Oranges .Potatoes . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 7:46 A.M., an observation, interview and record review was conducted with Dietary Supervisor (DS) 1 and DS 2, in the conference room. DS 1 stated that they did not have an in-house Registered Dietician (RD) but have a consultant filling in for now. DS 1 stated she knew Resident 84 preferred a renal diet versus a no added salt (NAS), carbohydrate controlled (CCHO) diet. DS 1 stated she completed Resident 84's dietary evaluation titled Dietary Profile on 10/24/24 and stated that the evaluation indicated Resident 84's dislikes included, orange juice/oranges, tomatoes, fresh potatoes, spinach, peas, beef, and pork. DS 1 stated for a renal diet, Resident 84 should not be served orange juice, fresh oranges, tomatoes, fresh potatoes and spinach. DS 1 stated that it was Resident 84's preference to not be served peas, beef and pork. DS 1 and DS 2 was shown a picture of Resident 84's meal tray with the meal tray card. DS 1 and DS 2 stated that the picture looked like it was the menu that was served on Sunday 1/12/25. DS 1 stated that the kitchen and nursing staff should have looked at Resident 84's meal tray card to see Resident 84's preference list and not serve Resident 84 what was on the dislikes and prepared a menu that substituted his dislikes that was nutritionally equivalent. DS 1 and DS 2 stated not following Resident 84's preference would make him unhappy. DS 1 stated the only way the kitchen and nursing staff would know about Resident 84's preference would be to look at the meal tray card because the preferences was not listed in Resident 84's orders or care plan. On 1/14/25 at 8:31 A.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 was lying in bed with a meal tray on his bedside table. Resident 84 stated I received pork and toast for breakfast and pork is on my dislikes list. They [facility staff] should already know while pointing to his meal tray. Resident 84 further stated, if the facility continued to not honor his meal preferences he could loose weight in an unhealthy way. On 1/14/25 at 8:37 A.M., an observation, interview and record review was conducted with LN 2, in the nursing station. LN 2 stated that it was the LN's responsibility to check the trays and check their dietary sheets to make sure that the ordered diet was being served before any residents ate the food that was being served for safety. LN 2 stated that the dietary sheets are Medical Doctor (MD) orders and does not show any preferences, but the actual meal tray card does. LN 2 stated for renal/kidney orders oranges are usually not acceptable because it spikes renal [sic], spikes the blood sugar and it's rich in potassium and are not good for the kidneys. LN 2 was shown a picture of Resident 84's breakfast meal tray taken on 1/12/25. LN 2 stated that Resident 84's preferences according to his meal tray card should be honored. LN 2 stated that Resident 84 should not have been served with orange and peas because it was what Resident 84 disliked. LN 2 stated the menu should have been substituted with foods that were nutritionally adequete and honored Resident 84's preference. LN 2 stated that the MD orders would not include a resident's preference, but it should be included in a person-centered care plan because this would help guide the nursing staff on how to care for Resident 84. LN 2 stated Resident 84 has CKD stage four and has a care plan with the diagnosis that does not include his food preferences. LN 2 stated that Resident 84's nutritional care plan was not person-centered and should include Resident 84's food preference since looking at the meal tray card was missed and could validate the plan of care of how to take care of Resident 84 to prevent a decline in Resident 84's nutritional health status. On 1/15/25 at 8:52 A.M., an interview and record review was conducted with the Director of Nursing (DON), in the DON's office. The DON stated that Resident 84's nutritional care plan was not person-centered and should be person centered to reflect his preferences. The DON stated it was important for Resident 84's care plan to be person centered because this guides the care, we (facility staff) should be providing for Resident 84 to promote his physical, mental and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled COMPREHENSIVE PERSON-CENTERED CARE PLANNING dated November 2018, indicated .Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .the comprehensive care plan will also be reviewed and revised at the following times: i. onset of new problems; ii. change of condition; iii. in preparation for discharge; iv. To address changes in behavior and care . 47956 2. A review of Resident 9's admission record indicated Resident 9 was admitted on [DATE] with a diagnosis of Congestive Heart Failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and admitted to Hospice on 1/4/25 with a diagnosis of End-Stage Heart Failure (the most severe form of heart failure, when the heart is too weak to pump blood effectively). During an observation on 1/12/25 at 9:25 A.M., Resident 9 was observed in bed, responsive to voice with low single word answers. During an interview on 1/14/25 at 10:19 A.M., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated a Care plan is a patient centered record where other staff can learn about the patient. Care plans come from the doctor. You can generate a new plan of care, but it is based on a doctor's order. LVN 2 stated All changes in resident status or goals of care need to have a care plan. During an interview and record review on 1/15/25 at 10:55 A.M., with the Director of Nursing (DON), in the DON's office. The DON stated Yes, [Resident 9] was admitted to hospice on 1/4/25. Following a review of Resident 9's care plans, the DON stated, There is no care plan for [Resident 9] to be on hospice. The DON further stated [Resident 9] would not have a comprehensive resident centered care plan since hospice is missing. A review of the facility's policy and procedure titled COMPREHENSIVE PERSON-CENTERED CARE PLANNING dated November 2018, indicated .Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .the comprehensive care plan will also be reviewed and revised at the following times: i. onset of new problems; ii. change of condition; iii. in preparation for discharge; iv. To address changes in behavior and care . 3. A review of Resident 198's admission record indicated Resident 198 was admitted on [DATE] with a diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During an observation on 1/12/25 at 10:50 A.M., Resident 198 was observed ambulating through facility and outside to the smoking area without the use of assistive devices. During an interview on 1/13/25 at 8:50 A.M., with the Administrator (ADM). The ADM stated on 1/2/25, Resident 198 came out of the door, set off the alarm, went past two residents, climbed over the fence, and went toward the church. The staff followed and Resident 198 was caught at the church and returned to the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 1/15/25 at 10:50 A.M., with the Director of Nursing (DON), in the DON's office. The DON stated Care Plans are individualized treatment programs for each resident. They are based on diagnoses, function, mental ability and they involve all areas of the facility. The DON stated [Resident 198] had a wandering care plan but it was not individualized enough based on the records from the hospital. Record reviews were conducted on 1/15/25 that indicated: - An Elopement Risk binder, Resident 198 is not listed. The binder is listed as last updated 6-19-24. - Psychiatric Consultation Note dated 12/20/2024, the note states She (Resident 198) is forgetful and has attempts to wander off by herself. - Hospitalist Progress note dated 12/24/2024, the note states .given the patients (Resident 198) elopement risk . - Psychiatric Consultation Follow up Note dated 12/24/2024, the note states .needs redirection as she (Resident 198) wanders off . A review of the facility's policy and procedure titled COMPREHENSIVE PERSON-CENTERED CARE PLANNING dated November 2018, indicated .Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .the comprehensive care plan will also be reviewed and revised at the following times: i. onset of new problems; ii. change of condition; iii. in preparation for discharge; iv. To address changes in behavior and care .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to ensure interventions for skin breakdown and/or pressure injury (bed sores) for one of five sampled residents (47) was maintained. Resident 47 had a low air loss mattress (LAL mattress: An air mattress to prevent pressure injury) for prevention of skin breakdown that were not set to the residents' current weight. This failure had the potential for Resident 47 to develop a pressure injury. Findings: 1. Resident 47 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a lung disease making it difficult to breathe) per the Admission Record. An observation was conducted on 1/12/25 at 9:17 A.M. Resident 47 was observed laying in bed with a LAL mattress set to static mode (no alternating pressure) and set for a resident weighing 400 pounds. A review of Resident 47's record was conducted on 1/14/25. Resident 47 had an active physician's order for Bariatric low air loss mattress, set to resident weight ., ordered 3/11/24. Resident 47 weighed 233.4 pounds on 12/5/24. An interview was conducted with Certified Nurse Assistant (CNA) 31 on 1/14/25 at 9:14 A.M. CNA 31 was shown photos of Resident 47's LAL mattress pump that was taken on 1/12/25. CNA 31 stated the LAL mattress pump for Resident 47 was on the wrong setting. CNA 31 stated if the LAL mattress pump was not on the correct setting, it may cause the resident to develop a pressure injury because the mattress would be too firm. An interview with Licensed Nurse (LN) 2 was conducted on 1/14/25 at 9:52 A.M. LN 2 was shown photos of Resident 47's LAL mattress pump that was taken on 1/12/25. LN 2 stated the pump was in the incorrect setting. LN 2 stated it was important for the LAL mattress pump to be on the correct setting to prevent pressure injury. An interview was conducted with the Director of Nursing (DON) on 1/15/25 at 9:56 A.M. The DON was shown photos of Resident 47's LAL mattress pump that was taken on 1/12/25. The DON stated if the resident was on a firm mattress consistently, then the resident would not get the full benefit of being on a LAL mattress which would be to prevent pressure injury. A review of the manual for [LAL Mattress Brand] indicated .General Operation .5. According to the weight and height of the patient, adjust the pressure setting .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 39448 Based on interview and record review, the facility failed to ensure that food temperatures were checked before serving to residents for two of 11 sampled days (10th, 11th). This failure placed residents at an increased risk of food-borne illness. Findings: On 1/12/25 at 7:35 A.M., a record review was conducted of the Food Temperature Log, dated January 2025. The log was blank for breakfast and lunch on the 10th and the 11th. On 1/13/25 at 11:45 A.M., an interview was conducted with Dietary Supervisor (DS) 1. DS 1 stated, [NAME] 1 was responsible for filling out the missing temperatures on the Food Temperature Log on 1/10/25, and [NAME] 2 was responsible for the missing temperatures on 1/11/25. DS 1 further stated, the Food Temperature Log should have been filled out at the time the temperatures were taken. On 1/13/25 at 12:10 P.M., an interview was conducted with [NAME] 1. [NAME] 1 stated, he did not remember why he did not fill out the Food Temperature Log on 1/10/25, but he may have forgotten to fill it out. Cook 2 was not available for interview. Per the facility's policy, titled Food Temperatures, revised 9/28/23, .Record the readings on .Food Temperature Log at the beginning of the tray line (placing food on plates for meals) .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 39448 Based on observation, interview, and record review, the facility failed to ensure that dietary staff were trained to properly test the strength of kitchen sanitizer for two of two sampled dietary staff (Cook 1, Dietary Aide 2). As a result, there was an increased risk of food-borne illness. Findings: On 1/13/25 at 9 A.M., an interview and observation was conducted with [NAME] 1. [NAME] 1 stated that when testing the quaternary sanitizer (a sanitizing liquid) he needed to take a test strip and hold it in the liquid for 10 seconds before checking the color. [NAME] 1 demonstrated testing the quaternary sanitizer strength in a red bucket by holding a test strip in the liquid for four seconds. [NAME] 1 reiterated that the sanitizer strip had to be held in the liquid for 10 seconds. [NAME] 1 then retested the quaternary sanitizer strength by holding the strip in the liquid for four seconds. On 1/13/25 at 9:02 A.M., an observation was conducted of the container for the test strips used by [NAME] 1 to test the sanitizer. The container read, .Test Paper IMMERSE FOR 10 SECONDS . On 1/13/25 at 9:15 A.M., an interview was conducted with Dietary Aide (DA) 2. DA 2 stated, he did not test the sanitizer in the red buckets and he did not know how to do so. On 1/13/25 at 9:16 A.M., an interview was conducted with Dietary Supervisor (DS) 1. DS 1 stated, all kitchen staff should have known how to test the sanitizer in the red buckets. DS 1 then instructed DA 2 on how to test the sanitizer. On 1/13/25 at 9:17 A.M., an observation was conducted. DA 2 demonstrated testing the sanitizer by holding the test strip in the liquid for 13 seconds. On 1/13/25 at 12:32 P.M., an interview was conducted with the Administrator. The Administrator stated, DA 2 had not yet completed his initial competencies (a checklist to ensure new employees knew how to do the tasks of their job). On 1/14/25 a review was conducted of DA 2's employee file. DA 2 was hired on 10/15/24 (90 days before the observed sanitizer testing). The file did not have any evidence of an orientation or training specific to DA 2's role in the kitchen. On 1/14/25 at 1:45 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated, the competencies for dietary staff should have been completed by the DS. Per the facility's policy, titled Pot and Pan Cleaning, revised 6/22/23, .Test quaternary sanitizer for adequacy using appropriate test strips .

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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** 48263 Based on observation, interview, and record review, the facility failed to ensure one of 29 sampled residents' (Resident 84) planned meal tray card (guidance to staff on what to serve for a meal to a resident) and menu was nutritionally substituted according to preferences to promote nutritional adequacy to current health status. This failure had the potential to result in a poor nutritional intake and weight loss. Cross-reference F656 Findings: 1. A review of Resident 84's Admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses which included a history of Chronic Kidney Disease Stage four (CKD stage 4- kidneys are moderately or severely damaged and are not properly filtering waste from your blood). A record review of Resident 84's minimum data set (MDS - a federally mandated resident assessment tool) dated 10/28/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 84 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 1/12/25 at 10:19 A.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 stated that he was a kidney patient and at the border of not having to need dialysis. Resident 84 stated that the facility was consistently serving meals that were not good for him because he was a kidney patient. Resident 84 further stated they [the facility staff] feed me trash I cannot eat such as fruits like oranges that are high in potassium (a mineral that is essential to body functions but an excess of potassium can build up with kidney disease due to the kidney's unable to remove the mineral from the body that could have harmful health effects). On 1/12/25 at 1:22 P.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 had a meal tray on his bedside table that included green peas, mashed potatoes, a bitten slice of chicken and oranges on the side. Resident 84 stated he did not like green peas, potatoes and could not eat the oranges because it is not good for my kidneys and it's on my dislikes list. Resident 84's meal tray card indicated, Dislikes .Oranges .Potatoes . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 7:46 A.M., an observation, interview and record review was conducted with Dietary Supervisor (DS) 1 and DS 2, in the conference room. DS 1 stated that they did not have an in-house Registered Dietician (RD) but have a consultant filling in for now. DS 1 stated she knew Resident 84 preferred a renal diet versus a no added salt (NAS), carbohydrate controlled (CCHO) diet. DS 1 stated she completed Resident 84's dietary evaluation titled Dietary Profile on 10/24/24 and stated that the evaluation indicated Resident 84's dislikes included, orange juice/oranges, tomatoes, fresh potatoes, spinach, peas, beef, and pork. DS 1 stated for a renal diet, Resident 84 should not be served orange juice, fresh oranges, tomatoes, fresh potatoes and spinach. DS 1 stated that it was Resident 84's preference to not be served peas, beef and pork. DS 1 and DS 2 was shown a picture of Resident 84's meal tray with the meal tray card. DS 1 and DS 2 stated that the picture looked like it was the menu that was served on Sunday 1/12/25. DS 1 stated that the kitchen and nursing staff should have looked at Resident 84's meal tray card to see Resident 84's preference list and not serve Resident 84 what was on the dislikes and prepared a menu that substituted his dislikes that was nutritionally equivalent. DS 1 and DS 2 stated not following Resident 84's preference would make him unhappy. On 1/14/25 at 8:31 A.M., an observation and interview was conducted with Resident 84, in Resident 84's room. Resident 84 was lying in bed with a meal tray on his bedside table. Resident 84 stated I received pork and toast for breakfast and pork is on my dislikes list. They [facility staff] should already know while pointing to his meal tray. Resident 84 further stated, if the facility continued to not honor his meal preferences he could loose weight in an unhealthy way. On 1/14/25 at 8:37 A.M., an observation, interview and record review was conducted with Licensed Nurse (LN) 2, in the nursing station. LN 2 stated that it was the LN's responsibility to check the trays and check their dietary sheets to make sure that the ordered diet was being served before any residents ate the food that was being served for safety. LN 2 stated that the dietary sheets are Medical Doctor (MD) orders and does not show any preferences, but the actual meal tray card does. LN 2 stated for renal/kidney orders oranges are usually not acceptable because it spikes renal [sic], spikes the blood sugar and it's rich in potassium and are not good for the kidneys. LN 2 was shown a picture of Resident 84's breakfast meal tray taken on 1/12/25. LN 2 stated that Resident 84's preferences according to his meal tray card should be honored. LN 2 stated that Resident 84 should not have been served with orange and peas because it was what Resident 84 disliked. LN 2 stated the menu should have been substituted with foods that were nutritionally adequate and honored Resident 84's preference. On 1/15/25 at 8:42 A.M., an interview and record review was conducted with the Director of Nursing (DON), in the DON's office. The DON stated his expectations was for the dietary staff to honor Resident 84's meal preferences. The DON stated that Resident 84's menu should have been substituted and followed according to nutritional equivalencies for Resident 84's dislikes with the peas, oranges and pork. The DON further stated if we don't offer nutritional alternatives for Resident 84 that complications such as weight loss can happen. A review of the facility's policy and procedure titled DIETARY PROFILE and RESIDENT PREFERENCE INTERVIEW revised 4/21/22, indicated .The Dietary Department will provide residents meals consistent with their preferences and Physician's order as indicated on the tray card. A. If a preferred item is not available, a suitable substitute should be provided .

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	055795	A. Building B. Wing	01/15/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956 Based on observation, interview, and record review, the facility failed to prepare food in a form to meet the needs of one of six sampled residents (Resident 27). This failure had the potential to cause unintended weight loss and medical complications. Findings Per Resident 27's Admission record, Resident 27 was admitted on [DATE] with diagnoses including Cerebral Infarction (blood loss to the brain) and End Stage Renal Disease (ESRD-irreversible kidney failure). A record review of Resident 27's minimum data set (MDS - a federally mandated resident assessment tool) dated 12/12/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 27 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. During an observation on 1/12/25 at 12:45 P.M. A lunch time meal tray was delivered to Resident 27. The Meal ticket stated chopped meat. The Plate had one quarter inch slice of meat. During an interview on 1/12/25 at 12:45 P.M. with Resident 27, Resident 27 stated he has limited use of hands and used adaptive devices for utensils. Resident 27 stated he is unable to use a knife and fork in combination to cut meat or vegetables. Resident 27 stated he will be unable to eat the meat in its current form and that is why he has asked for chopped meat. During an interview on 1/15/25 at 8:35 A.M. with Certified Nursing Assistant 25 (CNA 25), CNA 25 stated when we get the trays, the nurses check the slips and make sure that they match the trays. I can kind of read slips. CNA 25 further stated when we get our 4 day training, we get training on the different consistencies. Speech therapists sometimes come and talk to us as well, if they are going to upgrade diets. CNA. 25 concluded A resident could choke if they didn't have the correct diet. During an interview on 1/15/25 at 9:49 A.M. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated When meals are passed out, we have two licensed nurses at the tray cart. One confirms with the meal orders, and the other confirms with the meal ticket. We look at the food to make sure it matches with the order and the ticket. if it doesn't match then we send it back to the kitchen. Because of the two checks a wrong meal should not get to the resident. If it does, the resident might choke, or the resident might be allergic to something in the meal. During an interview on 1/15/24 at 10:55 A. M. with the Director of Nursing (DON), the DON stated we compare the diet order to the meal tag. We go by the diet order and have the kitchen update the tag. The DON further stated That tag says chopped meat and it is not, that's on me I checked that. If they had dysphasia, it could cause choking. It's not acceptable. (continued on next page)

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled DIETARY PROFILE and RESIDENT PREFERENCE INTERVIEW revised 4/21/22, indicated .The Dietary Department will provide residents meals consistent with their preferences and Physician's order as indicated on the tray card .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation and interview, the facility failed to ensure: 1. Food was discarded before the expiration date 2. Food containers were labeled after opening 3. Dietary staff had their facial hair covered while in the kitchen for one of one kitchens. These failures placed residents at an increased risk of food-borne illness. Findings: 1. On [DATE] at 7:50 A.M., an observation was conducted of the walk-in refrigerator in the kitchen. There was a container of dill pickle relish with a use by date of [DATE]. On [DATE] at 7:55 A.M., a concurrent observation and interview was conducted with [NAME] 1. [NAME] 1 stated, the dill pickle relish was past it's use by date and should have been thrown out. On [DATE] at 9:10 A.M., an interview was conducted with Dietary Supervisor (DS) 1. DS 1 stated, the expired relish should have been thrown out. The facility's policy, titled Food Storage and Handling, revised [DATE], did not have guidance on how to handle pickled food, or general guidance on use by dates. 2. On [DATE] at 7:50 A.M., an observation was conducted of the walk-in refrigerator in the kitchen. The following food items were opened and were not labeled with a use by date: - A bag of shredded cheddar and Monterey jack cheese. - A Bag of shredded lettuce. - A reusable container was filled with a substance that appeared to be applesauce. The container was unlabeled. On [DATE] at 7:55 A.M., a concurrent observation and interview was conducted with [NAME] 1. [NAME] 1 stated, the applesauce, cheese, and lettuce should have been labeled with their use by dates when they were opened. [NAME] 1 further stated that the bags of cheese and lettuce should have been moved into reusable containers once the bags were opened instead of being tied off, but there were no more containers available to put them in. On [DATE] at 9:10 A.M., an interview was conducted with Dietary Supervisor (DS) 1. DS 1 stated, all opened food in the fridge should have been labeled with the date they were opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy, titled Food Storage and Handling, revised [DATE], .All items will be correctly labeled and dated . 3. On [DATE] at 7:40 A.M., an observation and interview was conducted with Dietary Aide (DA) 3. DA 3 was observed preparing breakfast meal trays in the kitchen, and his beard was uncovered. DA 3 stated, he was required to cover the hair on the top of his head while in the kitchen, but not the hair on his face. On [DATE] at 9:10 A.M., an interview was conducted with Dietary Supervisor (DS) 1. DS 1 stated, that dietary staff were required to wear a beard net if they had facial hair. Per the facility's policy, titled Dietary Department - Infection Control, revised [DATE], .Cover hair, beard, and mustache with an effective hair restraint .while in any kitchen and food storage area .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48263

Based on observations, interviews, and record review, the facility failed to follow their infection control policies and procedures to prevent the spread of infection and cross contamination when:

1. Resident 72's oxygen supplies were not stored properly.

2. The facility did not have an infection surveillance tracker to properly conduct a contact tracing for residents with respiratory illness.

3. The facility did not properly screen staff and visitors during an active coronavirus (COVID19- a virus that can cause severe respiratory illness) outbreak.

This failure had the potential to increase the spread of infection for all residents, staff and visitors in the facility. The facility census was: 95.

Findings:

1. A review of Resident 72's Admission Record indicated Resident 72 was readmitted to the facility on [DATE] with diagnoses which included a history of cerebral Infarction (type of stroke, when the part of the brain tissues dies and loss of blood flow to the brain).

A record review of Resident 72's minimum data set (MDS - a federally mandated resident assessment tool) dated 11/21/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 72 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits.

On 1/12/25 at 8:55 A.M., an observation was conducted with Resident 72's roommate, in Resident 72's roommate's room. Resident 72's oxygen tubing and concentrator was seen at Resident 72's roommate's side of the room divided by a curtain. The unlabeled oxygen tubing was on the floor with an oxygen concentrator and humidifier unidentifiable of Resident 72's use.

On 1/12/25 at 10:41 A.M., an observation was conducted with Resident 72's roommate, in Resident 72's room. Resident 72's oxygen tubing was in the same position as the previous observation (on the floor and unlabeled) along with the oxygen concentrator and humidifier still at Resident 72's roommate's side of the room.

On 1/12/25 at 12:42 P.M., an observation was conducted with Resident 72's roommate, in Resident 72's room. Resident 72's roommate was resting in bed. The oxygen tubing was seen in Resident 72's roommate's side of the room remained unlabeled and was wrapped around the oxygen concentrator.

On 1/13/25 at 7:15 A.M., a clinical chart review was conducted on Resident 72's Medical Doctor (MD) orders. Resident 72's MD order's dated 1/5/25 indicated, Oxygen @2 L/min [liters per minute] to keep 02 Sat 92% every shift .).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 8:08 A.M., an observation was conducted on Resident 72, in Resident 72's room. Resident 72 was asleep in bed not using oxygen. On 1/13/25 at 9:34 A.M., an interview was conducted with LN 5, outside of Resident 72's room. LN 5 reviewed photos of Resident 72's oxygen tubing and supplies taken on 1/12/25 at 8:56 A.M., 9:53 A.M., 10:40 A.M., and 12:43 P.M. LN 5 stated the oxygen tubing should be stored in a clear plastic bag that is labeled with Resident 72's name, dated and not the floor to keep the tubing clean and prevent cross contamination. LN 5 stated the oxygen concentrator and oxygen supplies should not be placed in Resident 72's roommate's side of the room and should be within Resident 72's side of the room. LN 5 stated that he did see that Resident 72's oxygen concentrator and supplies placed at his roommates side of the room which should not be there to prevent cross-contamination. LN 5 stated it was an infection control issue because the oxygen tubing was on the floor and not labled and we would not know if he [Resident 72] used it or not. LN 5 further clarified this would cause confusion or might cause staff to mistakenly put the oxygen on Resident 72's roommate instead of Resident 72. On 1/13/25 at 11:17 A.M., a joint interview and record review was conducted with the Infection Preventionist (IP). The IP nurse stated Resident 72 had oxygen orders which were PRN [as needed] and confirmed that his roommate did not have any oxygen orders. The IP reviewed photos of Resident 72's oxygen tubing and supplies taken on 1/12/25 at 8:56 A.M., 9:53 A.M., 10:40 A.M., and 12:43 P.M. The IP nurse stated Resident 72's oxygen tubing should be stored in a bag away from the floor with a name, date, and labeled along with the concentrator and oxygen supplies to remain in Resident 72's side of the room to avoid confusion, safety concerns, and prevent cross contamination with a wrong resident. On 1/15/25 at 8:09 A.M., an interview was conducted with the Director of Nursing (DON). The DON reviewed photos of Resident 72's oxygen tubing and supplies taken on 1/12/25 at 8:56 A.M., 9:53 A.M., 10:40 A.M., and 12:43 P.M. The DON stated Resident 72's oxygen tubing should be labeled, dated and off the ground stored in a plastic bag. The DON stated it was important that the oxygen concentrator and oxygen supplies be stored appropriately in Resident 72's side of the room to avoid confusion. The DON stated if Resident 72's roommate was confused they [Resident 72's roommate] might use it and cause an improper use of oxygen and also for infection control practices that could be a risk for cross-contamination. A review of the facility's policy and procedure titled INFECTION CONTROL-POLICIES & PROCEDURES dated January 1, 2012, indicated, .Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public . The Policy and procedure did not indicate infection control measures specific to oxygen supplies and storage methods. 50175 2. A tour of the facility was conducted on 1/12/25 at 7:56 A.M. One room was observed to have transmission-based precautions (isolation to prevent the spread of infection). An interview and record review was conducted on 1/14/25 at 10:53 A.M. with the Infection Preventionist (IP). Per the IP, there was no infection surveillance located for the year 2024 and for January 2025. The IP stated it was important to have an infection surveillance tracker to know who had an infection within the facility and to help prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up interview was conducted with the IP on 1/15/25 at 9:20 A.M. The IP stated Resident 63 tested positive for COVID 19 on 1/6/25. The IP stated Resident 244 was the second resident to test positive for COVID-19 on 1/13/25. The IP stated having more than one resident test positive for COVID 19 meant there was an outbreak. An interview was conducted with the Director of Nursing (DON) on 1/15/25 at 9:39 A.M. The DON stated it was important to have an up-to-date infection surveillance tracker to help control the spread of infection. A follow-up interview was conducted with the IP on 1/15/25 at 10:56 A.M. The IP stated there was no contact tracing done after the first COVID 19 case on 1/6/25. A review of the facility's Covid-19 Mitigation Plan, revised 8/2/23, indicated .An outbreak is defined as: [greater than or equal to] 1 facility-acquired COVID-19 case in a resident .The facility will perform contact tracing to identify any HCP (healthcare personnel) who have had a high-risk exposure or resident who has had a high-risk close contact with the individual with [COVID-19] . A review of the facility's policy titled Infection Control Surveillance, revised 3/1/14, indicated .The Infection Preventionist conducts ongoing surveillance for HAIs (Healthcare-associated Infections) .that have substantial impact on potential resident outcome, and that require transmission-based precautions and other preventative interventions . A review of the facility's policy titled Management of COVID 19, revised 10/11/22, indicated .Perform contact tracing for both suspected and confirmed cases and document results on the Contact Tracing Log . 3. An interview and record review was conducted with Certified Nurse Assistant (CNA) 32 on 1/15/25 at 7:30 A.M. A binder at the nursing station was reviewed and found to have a screening form for staff to complete and indicate whether or not they have symptoms of COVID-19. According to the screening sheets in the binder, CNA 32 stated the staff started screening for COVID-19 symptoms on 1/14/25. An interview was conducted with the Infection Preventionist (IP) on 1/15/25 at 9:20 A.M. The IP stated Resident 63 tested positive for COVID 19 on 1/6/25. The IP stated Resident 244 was the second resident to test positive for COVID-19 on 1/13/25. The IP stated having more than one resident test positive for Covid 19 meant there was an outbreak. The IP stated screening for staff started on 1/14/25, and should have started on 1/12/25 when Resident 244 was sent to the hospital with symptoms of COVID 19. The IP stated it was important to do screening for staff and residents to control the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint interview and record review with the Administrator (ADM), Receptionist, and Activities Director (AD) was conducted at the reception desk on 1/15/25 at 10:35 A.M. A visitor log titled Daily Screening Log of Visitors, Vendors, and Medical Providers (non-facility employees), located at the Reception Desk, ranging from 12/23/24 through 1/15/25 was reviewed. The visitor log included a screening tool where the visitor would indicate their name, who they were visiting, and if they had any symptoms of COVID 19 such as cough, chills, and difficulty breathing. Multiple entries indicated the visitor's name but did not indicate whether or not the visitor exhibited symptoms of COVID-19. Some entries were not dated. The ADM, receptionist, and AD stated some of the screenings were incomplete. The Receptionist stated it was important to do a complete screening to stop the spread of infection within the facility. The ADM stated the outbreak of COVID-19 started on 1/13/25, and the screening of visitors were inconsistent. A review of the facility's COVID-19 Mitigation Plan, revised 8/2/23, indicated .Any visitor entering the facility . must adhere to the following: Visitors will sign in electronically or on the visitors' log and be asked to leave information to facilitate contact tracing, full name, date, contact information, who they are visiting .All visitors must be educated to screen themselves prior to entry . A review of the facility's policy titled Management of COVID-19, revised 10/11/22, indicated .Visitors will self-screen upon visiting .Any person who refuses screening will not be allowed into the Facility .Any person, who meets any of the temperature or symptom criteria will not be permitted to enter the Facility .For those permitted entry, the visitor must pass all self-screening criteria .

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to ensure two of 32 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) were not occupied by more than four residents This failure could potentially cause overcrowding and compromise the quality of care for the residents occupying the six-bed rooms. Findings: A tour of the facility was conducted on 1/12/25 at 7:41 A.M. At 8:12 A.M., room [ROOM NUMBER] was observed to occupy six residents. room [ROOM NUMBER] was also observed to occupy six residents. An interview and record review was conducted with the Administrator (ADM) on 1/13/25 at 3:08 P.M. The Client Accommodations Analysis was received indicating rooms [ROOM NUMBERS] each had a capacity for six residents. The Analysis indicated Bedroom [ROOM NUMBER] and 132 had a bedroom waiver. The ADM stated the facility did not have any room waivers. The ADM stated the last room waiver was from 2012. A follow-up interview was conducted with the ADM on 1/15/25 at 9:02 A.M. The ADM stated it was important to have a waiver to follow regulations.

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record reviews, the facility failed to follow their smoking policy for two of 17 residents (Residents 18 and 40) reviewed for smoking and tobacco use. This deficient practice had the potential for accidents and injuries. Findings: 1. A review of Resident 18's Admission Record indicated Resident 18 was readmitted to the facility on [DATE] with diagnoses which included a history of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 18's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/29/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 18 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. Resident 18's MDS also indicated Resident 18 was a smoker. On 1/14/25 at 12:41 P.M., a record review was conducted on Resident 18's tobacco care plan revised 2/1/24 indicated, The resident is able to; light own cigarette. Resident 18's document titled SMOKING and SAFETY ASSESSMENT was completed on 11/8/23, 1/30/24 and 4/29/24. On 1/14/25 at 12:56 P.M., an interview was conducted with Resident 18, in Resident 18's room. Resident 18 confirmed that he smokes during the smoking times offered by the facility in the smoking patio. On 1/14/25 at 1:44 P.M., an interview was conducted with the Activities Director (AD), in the conference room. The AD stated smoking assessments are conducted by the nursing staff on admission and should be done on a quarterly basis and change of conditions. The AD stated that she communicates with the MDS nurses who start the tobacco care plan, and it was her responsibility to update the smoker's list only. On 1/14/25 at 2:03 P.M., a joint interview and record review was conducted with the MDS nurse, in the MDS office. The MDS nurse stated that the last smoking assessment was completed on 4/29/24. The MDS nurse stated that the smoking assessment titled SMOKING and SAFETY ASSESSMENT should have been done on a quarterly basis. The MDS nurse stated that two quarterly assessments were missed (July 2024 and October 2024). The MDS nurse stated it was important to complete a smoking assessment for Resident 18 on a quarterly basis to evaluate the safety of smoking for Resident 18 and to capture an updated assessment to Resident 18's current health status. The MDS nurse also stated any changes regarding smoking safety should be updated on Resident 18's care plan to communicate to the facility staff that Resident 18 smokes and what care was required for smoking safety. (continued on next page)

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:57 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated his expectations was that Resident 18's quarterly SMOKING and SAFETY ASSESSMENT to be completed in a timely manner. The DON stated it was important to make sure the smoking assessment was updated to accommodate for any changes that need to be updated for Resident 18's plan of care for safety. A review of the facility's policy and procedure titled SMOKING POLICY undated, indicated Smoking assessment will be done upon admission, quarterly, annually and upon change of condition . 2. A review of Resident 40's Admission Record indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses which included a history of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 40's minimum data set (MDS - a federally mandated resident assessment tool) dated 8/26/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 7 points out of 15 possible points which indicated Resident 40 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. Resident 40's MDS also indicated Resident 18 was a smoker. On 1/12/25 at 4:11 P.M., an interview was conducted with Resident 40, in Resident 40's room. Resident 40 stated he was a smoker and had no concerns when he wanted to go out in the smoking patio for a cigarette. On 1/14/25 at 9:50 A.M., an interview with activities assistant (AA) 1 was conducted, in the smoking patio. AA 1 stated Resident 40 comes out to the smoking patio to smoke every now and then but was offered to smoke during smoking hours. AA 1 stated Resident 40 requires the use of a smoking apron. On 1/14/25 at 11:15 A.M., a record review was conducted on Resident 40's tobacco care plan revised 2/21/24 indicated, The resident requires supervision while smoking. Resident 40's document titled SMOKING and SAFETY ASSESSMENT was completed on 10/20/23, 12/7/23, 1/18/24, 4/18/24, and 7/22/24. On 1/14/25 at 1:44 P.M., an interview was conducted with the Activities Director (AD), in the conference room. The AD stated smoking assessments are conducted by the nursing staff on admission and should be done on a quarterly basis and change of conditions. The AD stated that she communicated with the MDS nurses who start the tobacco care plan, and it was her responsibility to update the smoker's list only. On 1/14/25 at 1:51 P.M., a joint interview and record review was conducted with the MDS nurse, in the MDS office. The MDS nurse stated that the last smoking assessment was completed on 7/22/24. The MDS nurse stated that the smoking assessment titled SMOKING and SAFETY ASSESSMENT should have been done on a quarterly basis. The MDS nurse stated that one quarterly assessment was missed (October 2024). The MDS nurse stated it was important to complete a smoking assessment for Resident 18 on a quarterly basis to evaluate the safety of smoking for Resident 40 and to capture an updated assessment to Resident 40's current health status. The MDS nurse also stated any changes regarding smoking safety should be updated on Resident 40's care plan to communicate to the facility staff that Resident 18 smokes and what care was required for smoking safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Brighton Place San Diego		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:32 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important that the SMOKING and SAFETY ASSESSMENT to be completed because resident's who smoke can change either better or worse for example holding a cigarette before versus not holding a cigarette presently.The DON further stated it could help us know if there may be a significant change with the residents [residents who smoke] for safety. A review of the facility's policy and procedure titled SMOKING POLICY undated, indicated Smoking assessment will be done upon admission, quarterly, annually and upon change of condition .