

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Brighton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1836 N. Fair Oaks Ave Pasadena, CA 91103	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on observation, interview and record review, the facility failed to develop a care plan (a document that outlines the facility ' s plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) to provide interventions swollen (enlargement caused by a buildup of fluid in the tissues) left hand for one of one sampled resident (Resident 1) in accordance with the facility policy.</p> <p>This failure resulted in the lack specific care interventions for Resident 1 ' s left hand swelling, with the potential to worsen Resident 1 ' s left hand condition and function.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record, indicated Resident was readmitted to the facility on [DATE] with diagnoses that included dementia (a condition characterized by progressive or persistent loss of intellectual functioning), repeated falls, muscle wasting (deterioration of muscle tissue) and atrophy (decrease in size), and acute kidney failure (the sudden and rapid loss of kidney ' s ability to filter waste and balance fluid in blood).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 3/8/2024, indicated Resident 1 had a moderately impaired cognitive (ability to think, remember, and reason) skills for daly decision making. Resident 1 required maximal assistance (staff does more than the effort to complete the task) with standing, transfers from bed to chair/chair to bed, bathing, dressing, toileting and personal hygiene and moderate assistance (staff does less than half the effort to complete the task) with eating and oral hygiene.</p> <p>A review of Resident 1 ' s X-Ray (an imaging study that takes pictures of bones and soft tissues) Results, dated 5/21/2024, indicated an Xray of Resident 1 ' s left hand was completed on 5/21/2024 due to Resident 1 having pain and swelling in the left hand.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review of Resident 1 ' s medical chart and interview on 5/30/2024 at 12:45 PM with the Director of Nursing (DON). The DON stated a care plan was not and should have been developed to address Resident 1 ' s left hand swelling. The DON stated there a care plan was important because it is a guide for staff to render care for Resident 1 ' s left hand pain and swelling. The DON also stated without a care plan for Resident 1 ' s left hand swelling, there was a risk for worsening of the swelling, increased pain and Resident 1 ' s ability to do things and function will be negatively affected.</p> <p>During a concurrent observation and interview on 5/30/2024 at 1:19 PM with DON and Resident 1, Resident 1 ' s left hand was observed with swelling. Resident 1 stated she was having pain in her left hand. The DON stated there was swelling in Resident 1 ' s left hand and that Resident 1 will be given pain medicine.</p> <p>A review of the facility ' s Policy & Procedure (P&P) titled, Change of Condition, revised 8/2017, indicated a care plan will be developed for any change of condition.</p> <p>A review of the facility ' s P&P titled, Comprehensive Care Plan, revised 12/2016, indicated comprehensive care plans must include services that are provided to attain or maintain the resident ' s highest practicable physical, mental and psychosocial well-being. The P&P also indicated the care plans will be modified as changes in the resident ' s care and treatment occur and are to include interventions to prevent avoidable decline in function.</p>		