STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555338	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Care Center	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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview and record review, the facility failed to follow its Facility Initiated Transfer /Discharge policy for (1) of three (3) sampled residents (Resident 1) by failing to: 1. Complete the Transfer Assessment form before transferring Resident 1 to Facility 2. 2. Complete a Discharge Summary to include documentation of Resident 1's basis for transfer to Facility 2. 3. Obtain a Physician's order for Resident 1 to be transferred to Facility 2. 4. Inform Resident 1 of which facility he was being transferred to. This deficient practice has the potential for an unsafe and inappropriate discharge. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included seizures (a sudden, uncontrolled burst of electrical activity in the brain), acute respiratory failure (occurs when you do not have enough oxygen in your blood) with hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P) Examination, dated 8/5/2024, the H&P indicated Resident 1 has fluctuating capacity to understand and make decision due to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/17/2024, the MDS indicated Resident 1 had severe impairment in cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 1 needed supervision or touching assistance (helper provides verbal cues, touching and contact guard assistance as resident completes the activity) in chair/bed-to-chair transfer, toilet transfer, walk 50 feet with two turns, and walk 10-150 feet. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Care Plan (CP), dated 4/15/2024, the CP indicated a goal for Resident 1 to be discharged to Facility 3 (lower level of care) when rehabilitation goals are met and when Resident 1 is medically stable. During a review of Resident 1's Interdisciplinary Team (IDT, a group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a resident) Care Plan Conference (CPC), dated 8/29/2024 at 10:10 AM, the IDT CPC indicated due to Resident 1's recent elopement episode, Resident 1 was being transitioned /discharged to Facility 2's (Skilled Nursing Facility) secured unit (a specialized area that provides a safe environment for people with dementia (loss of memory and other mental abilities severe enough to interfere with daily life) or Alzheimer's disease (a brain disorder that disables a person from performing everyday activities) as proper placement. During a review of Resident 1's Nurses' Progress Notes, dated 8/29/2024 at 2:17 PM, the Nurses' Progress Note indicated, at 11:20 AM, Resident 1 was discharged to Facility 2. During an interview with Administrator (ADM) on 9/4/2024 at 11:31 AM, ADM 1 stated on 8/28/24, he picked Resident 1 up where the local law enforcement found him after eloping. ADM stated he spoke to Resident 1 and told him that it was unsafe outside and does not want Resident 1 to get hurt. ADM 1 stated that he went straight to Facility 2 to drop Resident 1 off. ADM 1 stated he informed Resident 1 that he was transferring him to Facility 2 for his safety. ADM 1 stated he did not follow the discharge process and he did not know if there was a consent for discharge or if Resident 1 had to sign any discharge documents. During an interview with Resident 1 on 9/4/2024 at 2:11 PM, Resident 1 stated the Administrator 1 asked him if he wanted to be transferred to another facility. Resident 1 stated he was not made aware where would he be discharged . During a concurrent record review of Resident 1's Physician's order and medical record and interview with DON 1 on 9/4/2024 at 3:50 PM, DON 1 stated she cannot find a written or telephone order for Resident 1 to be transferred or to be discharged to Facility 2. DON 1 also stated, there was no discharge summary completed for Resident 1. DON 1 stated a discharge summary should have been completed because it ensures that care is coordinated and the resident transitions safely from one setting to another. DON 1 stated, Discharge Summary should include the discharge plan including the new facility's location, follow-up care including follow-up appointments and contact information for the continuing care provider, a post-discharge medications, information on their diagnosis, cognitive status, advance directives, and code status, coordination of care if the resident is being discharged to a different level of service, the reason for the resident's discharge and appeal rights. During a concurrent record review of Resident 1's Physician's order and interview with the Medical Records (MRD) on 9/5/2024 at 11:15 AM, MRD stated, Resident 1 did not have a discharge summary and a discharge order from the Physician. MRD stated, The licensed staff did the Discharge Comprehensive Form, which is only used when a resident was transferred at home. The staff completed the wrong form. The staff should have done a transfer assessment and discharge summary. MRD also stated, The ADM took the resident (Resident 1) straight to the other facility. Nobody did proper discharge documentation for the resident because there was no physician's order and discharge summary. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility- initiated, revised 10/2022, the P&P indicated once admitted to the facility, Residents have the right to remain in the facility. Facility initiated transfers and discharges, when necessary, must meet specific criteria and require resident/ representative notification and orientation, and documentation as specific in this policy. Facility - initiated transfer or discharge means a transfer or discharge which the resident objects to or did not originate through a resident's verbal or written request, and/or is not in alignment with the Resident's stated goals for care and preferences.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to ensure one (1) of three (3) sampled residents (Residents 1) did not elope from the facility as indicated in the facility's policy and procedure by failing to: 1. Provide adequate supervision on 8/28/2024 at 7PM. 2. Accurately assess Resident 1 for Risk for elopement (a form of unsupervised wandering that leads to the resident leaving the facility) 3. Develop a resident centered care plan to include specific interventions such as supervision to prevent elopement and implement use of wander guard (a bracelet that can be integrated with a resident's security system to alert staff when residents have wandered). This deficient practice resulted in Resident 1 from eloping the facility on 8/28/2024, which placed the resident at risk for injury, harm, and death. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included seizures (a sudden, uncontrolled burst of electrical activity in the brain), acute respiratory failure (occurs when you do not have enough oxygen in your blood) with hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P) Examination, dated 8/5/2024, the H&P indicated Resident 1 has fluctuating capacity to understand and make decision due to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/17/2024, the MDS indicated Resident 1 had severe impairment in cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 1 needed supervision or touching assistance (helper provides verbal cues, touching and contact guard assistance as resident completes the activity) in chair/bed-to-chair transfer, toilet transfer, walk 50 feet with two turns, and walk 10-150 feet. During a review of Resident 1's Care Plan (CP), dated 4/15/2024, the CP indicated Resident 1 is at risk for elopement, propels self in wheelchair independently, and with wandering and exit seeking behavior. CP Goal indicated Resident 1 will not leave the facility unsupervised. Interventions includes the following: Encourage participation in activities. Frequent rounds by staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ID band on Resident at all times Remind/ assist Resident that they need to remain inside the facility/patio. Resident is to be signed out by responsible party when leave of absence. Resident picture in clinical record. Wander guard device in place. Check for placement and functionality every shift. During a review of Resident 1's Elopement/Wandering Risk Assessment (EWRA) dated: 1. On 4/15/2024, the EWRA indicated Resident 1 has a score of 1 which indicated low risk. 2. On 8/4/2024, indicated Resident 1 has a score of 1 which indicated low risk. During an interview with the ADM 1 on 9/4/2024 at 11:55 AM, ADM 1 stated, to prevent elopement, the facility should identify residents who are at risk for elopement, perform elopement assessment, take a photo of the resident, make sure the residents have arm bands for identification, and frequent resident monitoring to establish whereabouts. The ADM stated Resident 1 was not monitored. During an interview with the Social Services Director (SSD) on 9/4/2024 at 1:10 PM, SSD stated, To prevent elopement, the staff should have monitored the resident (Resident 1) when there was no one in the lobby. The staff should have done rounds. During a concurrent record review of Resident 1's MDS and interview with the MDS Nurse (MDSN) on 9/4/2024 at 1:20PM, Resident 1's MDS Functional Abilities indicated Resident 1 needed supervision while Resident 1 was propelling his wheelchair. MDSN stated supervision means that the staff should always visually check on Resident 1. During a concurrent record review of Resident 1's Care Plan (CP) for Wandering and interview with the MDSN on 9/4/2024 at 1:27 PM, MDSN stated the Care plan should have been updated when Resident 1 was readmitted [DATE] to prevent the elopement incident. MDSN added, the CP was incomplete and was not resident specific because there was not enough intervention to address Resident 1's wandering behavior. During a concurrent record review of Resident 1's Elopement/Wandering Risk assessment dated [DATE] and interview with MDSN on 9/4/2024 at 1:32PM, MDSN stated, the Elopement Assessment was done incorrectly because it was not accurate. MDSN stated Resident 1 has a diagnosis of dementia (loss of memory and other mental abilities severe enough to interfere with daily life) and had a history of elopement, in accordance with Resident 1's MDS and Elopement/Wandering Risk assessment dated [DATE]. MDSN stated, The nurse who did the elopement assessment must have overlooked this. The MDSN stated, Resident 1 should have been assessed as at risk for elopement. MDSN stated, Resident 1 did not and should have been provided with a wander guard as indicated in Resident 1's CP to alert the staff if Resident 1 leaves the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1 on 9/4/2024 at 2:11 PM, Resident 1 stated he left the facility through the front door which was unlocked. Resident 1 stated there was no one in the lobby except for himself. Resident 1 stated he propelled his wheelchair out of the facility onto the sidewalk. During a concurrent record review of Resident 1's Nurses Progress Notes / Situation, Background, Assessment, Recommendation (SBAR, a verbal or written communication tool that helps provide essential, concise information, usually during crucial situation) and interview with Licensed Vocational Nurse 1 (LVN 1) on 9/4/2024 at 2:59 PM, LVN 1 stated, there was no documentation during the 3-11 shift of Resident 1 eloping. LVN 1 stated they had a fire drill on 8/28/2024 at 7 PM, so there was no supervision at the front door. LVN 1 stated Resident 1 had the opportunity to leave the facility unsupervised from the front door. LVN 1 stated the staff figured out that Resident 1 was missing during the shift change endorsement because Resident 1 was not inside his room. During a concurrent record review of Resident 1's Elopement/Wandering Risk Assessment, dated 8/4/2024 and interview with the Director of Nursing on 9/4/2024, at 3:23PM, the DON stated, Resident 1's elopement assessment score indicated 1 which was considered as low risk. The DON stated it was a wrong/ inaccurate assessment which led to the facility staff not being able to provide Resident 1 the care that he specifically needed. The DON stated the facility could have prevented the elopement incident if the assessment was accurate. The score should have been 9 which would indicate Resident 1 was at risk to wander, which also meant Resident 1 was at risk for elopement. During a concurrent record review of Resident 1's Care plan for Wandering and interview with the DON on 9/4/2024 at 3:29 PM, the DON stated, Care plan dated on 4/15/2024 should have been updated when Resident 1 was readmitted on [DATE]. The licensed staff should have re- assessed Resident 1 during readmission and revised the care plan. The DON stated a complete and resident centered care plan was important because it assists the staff to provide the proper care for residents. During a review of facility's policy and procedure (P&P) titled, Safety and Supervision of Residents revised 07/201, the P&P indicated Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's needs and identified hazards in the environment. During a review of facility's P&P titled, Wandering and Elopements revised 03/2019, the P&P indicated if identified as at risk for wandering, elopement or other safety issue, the Resident's care plan will include strategies and interventions to maintain the resident's safety.