

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 10/30/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</p> <p>Based on observation, interview, and record review the facility failed to prevent elopement (leaving the facility without the staff's knowledge and/or supervision) for one (1) of two (2) sampled residents (Resident 1) when Resident 1 left the facility through his room's sliding door and to the facility's emergency exit door located near the laundry room (Exit Door 1) and the alarm did not go on.</p> <p>This failure resulted in Resident 1 eloped on 10/28/2024 between 1:38 AM to 1:48 AM and Resident 1 was found on 10/29/2024 around 3:40 PM along Street 1 and 2 chatting with unknown individuals and the resident refusing to return to the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting left nondominant side, alcohol abuse (a pattern of drinking too much alcohol too often), and traumatic pneumothorax (condition that occurs when air builds up in the pleural space, the area between the lungs and chest wall, due to an injury).</p> <p>During a review of Resident 1's History and Physical Examination (H&P), dated 10/9/2024, indicated the resident has the capacity to understand his medical condition or his bill of rights (a patient's rights and responsibilities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 10/14/2024, the MDS indicated Resident 1 was able to follow commands, his cognition skills (process of thinking and reasoning) was moderate impaired for decision making. The MDS indicated Resident 1 required helper to do less than half of the effort for resident for the toilet, and personal hygiene. The MDS also indicated Resident 1 required less than half of the effort for change of position and transfer.</p> <p>During a review of Resident 1's risk for elopement care plan dated 10/8/2024, the risk for elopement care plan indicated Resident 1 was a low risk for elopement.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/29/2024 at 12:10 PM with Certified Nursing Assistant 1 (CNA1). CNA1 stated, they noticed on 10/28/2024 around 4 AM to 5 AM, Resident 1 was not in his bed, not in his own room nor restroom. CNA1 stated CNA1 saw after Resident 1 went missing on 10/28/2024 that the sliding door next to Resident 1's bed was wide open, and facility staff cannot locate the Resident 1 inside the facility. CNA1 stated he went out of the facility to search for Resident 1 in the facility's parking lot and he also searched Resident 1 on the nearby streets next to the facility's parking lot but was unable to find Resident 1. CNA1 also stated Resident 1 can be in danger if the resident cannot be found.</p> <p>During a telephone interview on 10/29/2024 at 2:10 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she got a report from CNA1 on 10/28/2024 between 4 AM to 5 AM that Resident 1 was missing, they then started the search of Resident 1, and they were not able to find Resident 1 inside the facility nor the facility's parking lot or the nearby streets. LVN1 stated the sliding door next to Resident 1's bed was wide open on 10/28/2024 after Resident 1 went missing. LVN1 also stated, the sliding door lead to the alleyway that leads to Exit Door 1. LVN 1 stated Exit Door 1 leads to the open facility's back parking lot. LVN1 stated Exit Door 1's alarm was broken, and it was not alarming when it is opened. LVN1 stated there was no other guarding tools to prevent Resident 1 from walking away from the facility by himself without notice of the facility staff. LVN1 stated Resident 1 could have walked away through the sliding door next to his bed to the alleyway towards Exit Door 1 early morning on 10/28/2024. LVN 1 stated, the Exit Door 1's alarm not working breached the monitoring system of residents' safety. The Exit Door 1 alarm is the only guarding tool to prevent residents from eloping from the facility. LVN1 stated Resident 1 can be in danger if the resident is not found as soon as possible. Resident 1's eloping from the facility can increase his risk of injury or accident to the resident.</p> <p>During a concurrent interview and review of facility's surveillance camera footage on 10/29/2024 at 9:20 AM with Administrator (ADM) and the Director of Nursing (DON), ADM and the DON verified, Resident 1 was last seen in the facility's surveillance video time stamped on 10/28/2024 between 1:38 AM to 1:48 AM and showed Resident 1 was seen in front of the laundry room walking towards Exit Door 1. ADM and the DON confirmed that the resident in the surveillance video who was walking toward Exit Door 1 was Resident 1 and that Resident 1 could have left the facility using Exit Door 1. ADM and the DON both stated Resident 1 is now listed in national missing person system by Local Police Department.</p> <p>During a concurrent observation and interview on 10/29/2024 at 10:02 AM with the DON in Resident 1's room, observed the sliding door in Resident 1's room was open and leads to the alleyway which leads to the facility's Exit Door 1. The DON confirmed Resident 1's room sliding door was open to the alleyway and this alleyway leads to Exit Door 1.</p> <p>During an observation on 10/29/2024 at 10:08 AM by the Exit Door 1, observed the Exit Door 1 can be opened from inside of the facility, without any lock and leads to the facility's back parking lot. The Exit Door 1 alarm did not turn on when the Exit Door 1 was opened.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and observation on 10/29/2024 at 10:46 AM with Maintenance Supervisor (MS) in front of Exit Door 1, MS stated the Exit Door 1's alarm did not turn on then the door was opened and it was not working since last year (2023) and he was not able to fix the alarm. MS stated he did not notify the administrator about the door alarm malfunction. MS stated residents can walk away from the facility through Exit Door 1 without the facility's staff's knowledge and this can create a safety issue to the resident.</p> <p>During a concurrent interview and record review on 10/30/2024 at 9:29 AM with Maintenance Consultant (MC), MC confirmed, Exit Door 1's alarm was not working since last year, and he did not notify ADM regarding the alarm malfunction. MC also stated the maintenance log did not include checking of the alarm of Exit Door 1 was functioning or not. MC stated residents can use the Exit Door 1 to leave the facility without alarming the facility staff. MC stated this can be a risk to residents' safety and could cause serious harm to the residents if residents left the facility as a result of no proper monitoring and/ or the Exit Door 1 alarm is not working.</p> <p>During an interview on 10/30/2024 at 11:40 AM with the DON, the DON stated resident's safety and supervision to prevent accidents are facility-wide priorities. The DON stated resident supervision is a core component of the systems approach to safety and the malfunction of Exit Door 1 alarm can be a breach of the resident's supervision system. The DON stated, as a result of the Exit Door 1's alarm not working, Resident 1 eloped from the facility without supervision or staff's knowledge on 10/28/2024.</p> <p>During an interview on 10/30/2024 at 12:10 AM with ADM, ADM stated emergency exit door's alarm need to be in a good working condition to function as a supervision and monitoring system to prevent Resident 1 and other resident from eloping the facility.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents revised July 2017, the P&P indicated:</p> <ul style="list-style-type: none"> o Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. o 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 assessed needs and identified hazards in the environment. <p>During a review of the facility's policy and procedure (P&P) titled Physical Environment Policy revised October 2021, the P&P indicated, maintain electrical power system for lighting all entrances and exits, fire detection, alarm and extinguishing systems and life support systems in good working condition. i.e. exits, alarm, fire doors and emergency generator. (not all conclusive)</p> <p>During a review of the facility's policy and procedure (P&P) titled Interior Maintenance Miscellaneous revised 10/18/2021, the P&P indicated door inspection procedures included check door alarms to ensure they are in good working order. E.g. exit door alarm.</p>		