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	03/08/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review the facility failed to ensure the call light was addressed in a timely manner (one of the major communication technologies that link nursing home staff to the needs of residents) for one (1) of 3 sampled residents (Resident 2). This deficient practice had the potential to result in a delay in care and services for Resident 2. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnosis which included dysphagia (swallowing difficulties), muscle weakness, hypothyroidism (thyroid gland does not produce enough thyroid hormones). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/21/2025, the MDS indicated Resident 2 ' s cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired. The MDS also indicated Resident 2 was dependent (helper does all the effort) on toilet hygiene, shower /bathe self, upper and lower body dressing, personal hygiene. During a concurrentobservation and interview on 3/7/2025 at 3:32 PM with certified nursing assistant (CNA 1), in the facility hallway, in front of nursing station 2, Resident 2 ' s call light was observed on. CNA 1 stated Resident 2 ' s call light was turned on and could hear Resident 2 speaking loudly and asking for assistance. LVN 5 was observed in nursing station 2. During a concurrent observation and interview on 3/7/2025 at 3:33 PM in Resident 2 ' s room, Resident 2 was observed calling for help, and Resident 2 ' s call light was observed on. Resident 2 stated needing her nurse, that was why her call light was on, and why she was calling for help. During a concurrent observation and interview on 3/7/2025 at 3:35 PM, with LVN 5 in nursing station 2, LVN 5 stated she was not the charge nurse for Resident 2, therefore did not address Resident 2 ' call light, or calls for help. During an interview on 3/8/2025 at 3:50 PM with LVN 3, LVN 3 stated addressing call lights and residents ' calls for help must be addressed as soon as possible. LVN 3 stated if we do not answer the call light, or check on the resident calling for help, the resident would feel helpless. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/8/2025 at 6:31 PM with the Director of Nursing (DON), the DON stated we have to work as a team, and that everybody (facility staff) must help each other, especially if a resident was heard calling for help. The DON stated there was a potential for accidents, such as falls. During a review of facility ' s Policies and Procedures (P&P) titled, Call Light Resident dated 9/2022, indicated Residents are provided with means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Calls for assistance are answered as soon as possible, but not later than 5 minutes. Urgent request for assistance is addressed immediately.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility failed to provide grooming services to one (1) of three (3) sampled residents (Resident 1) who were dependent with activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), in accordance with the facility ' s policy. This deficient practice resulted in Resident 1 ' s unkempt and dirty fingernails and toenails potentially leading to skin injury, infection, and scarring. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnosis which included sepsis (a serious condition in which the body responds improperly to an infection), dysphagia (swallowing difficulties) and depression. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/8/2025, the MDS indicated Resident 1 ' s cognitive skills (processes of thinking and reasoning) for daily decision making was intact. The MDS also indicated Resident 1 was dependent on personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands. During a review of Resident 1 ' s care plan initiated on 2/4/2025, the care plan indicated Resident requires assistance with ADL ' s ambulation, bathing, bed mobility, dressing, eating, locomotion, personal hygiene, toilet use, transfer. The care plan also indicated goal: will be clean, dry, odor free daily through review date. Interventions: assist with all ADL ' s as needed. During a concurrent observation and interview on 3/7/2025 at 9:06 AM in Resident 1 ' s room, with the Treatment Nurses (TN1), TN 1 stated that Resident 1 ' s fingernails and toenails were long, jagged (a rough, uneven shape or edge with lots of sharp points), and dirty with black stuff on it. During an interview on 3/8/2025 at 3:50 PM with license vocational nurse (LVN3), LVN 3 stated it was important for residents to have short, smooth and clean nails. LVN 3 stated long, and jagged nails could cause skin tears, scratches, and for older residents ' fragile skin, could cause bleeding. During a review of facility ' s Policies and Procedures (P&P) titled, Activities of Daily Living (ADL ' s), Supporting dated 3/2018, the P&P indicated A resident who are unable to carry out activities of daily living independently will receive the service to maintain good nutrition, grooming and personal and oral hygiene. During a review of facility ' s Policies and Procedures (P&P) titled, Fingernails/ Toenails, Care of dated 2/2018, the P&P indicated the purpose of this procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. The P&P indicated General Guidelines which included daily cleaning and regular [NAME]

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47362 Based on observation, interview, and record review, the facility failed to ensure the Direct Care Service Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) was updated in accordance with the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers. This deficient practice had the potential for residents and visitors to not be informed of the facility's census and staffing. Findings: During a concurrent observation and interview on 3/7/2025 at 8:38 AM with license vocational nurse (LVN 1), the DHPPD was observed in nursing station 1. LVN1 stated the DHPPD was not updated since the date observed indicated 3/4/25. During an interview on 3/7/2025 at 2:51 PM with LVN 2, LVN 2 stated nursing hours was posted in every station to indicate the number of Registered Nurse (RN), LVN, and Certified Nursing Assistants on that specific shift, based on the resident census. LVN 2 stated the DHPPD should be updated, and when the DHPPD was not updated, it would provide wrong information to the residents and staff. During a concurrent interview and record review on 3/82025 at 6:35 PM with the Director of Nursing (DON), the DON stated the facility ' s policy and procedure (P&P) titled Posting Direct Care Daily Staffing Numbers dated 1/2021, the indicated our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The P&P also indicated within two hours of the beginning of each shift, the number of license nurses and the number of unlicensed nursing personnel directly responsible for resident care is posted in a prominent location (accessible to resident and visitors) and in a clean readable format. The DON also stated the information recorded on the form shall include the following: a. The name of the facility b. The current date (the date for which the information is posted) c. The resident census at the beginning of the shift for which the information is posted d. Twenty-four (24) hour shift schedule operated by the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 1's Santyl ointment (ointment used to remove damaged or burned skin) was labeled indicating the Resident 1 ' s name, the route of administration, the medication dose, and the frequency of administration in accordance to the facility ' s policy and procedure titled, Labeling of Medication Containers. This deficient practice had the potential for Resident 1 to not receive medications as ordered or as directed. 2. Ensure medication cart 1 (med cart 1- a movable piece of equipment used in healthcare facilities to store, transport, and dispense medicines, medical supplies, and emergency equipment) was kept locked when unattended to prevent unauthorized access in accordance with the facility ' s P&P titled Security of Medication Cart. This deficient practice had the potential to result in unauthorized access of medications by residents, visitors and staff and predisposing them to possible medication overdose (taking a toxic or poisonous amount of a drug or medicine), unauthorized use of medications, adverse reactions (any unexpected or dangerous reaction to a drug), and drug-to-drug interactions (a reaction between two or more drugs or between a drug, and a food, beverage, or supplement). Findings: 1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnosis which included sepsis (a serious condition in which the body responds improperly to an infection), dysphagia (swallowing difficulties) and depression. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/8/2025, the MDS indicated Resident 1 ' s cognitive skills (processes of thinking and reasoning) for daily decision making was intact. The MDS also indicated Resident 1 was dependent on personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing /drying face and hands. During a review of Resident 1 ' s Order Summary Report, dated 1/20/2025, indicated a physician order, with a start date of 2/25/2025, for Santyl External Ointment 250 unit per gram (unit/gm, a metric unit for a small amount of mass or weight). Apply to sacrum (a large, triangular bone at the base of the spine) topically everyday shift for pressure injury (sores [ulcers] that happen on areas of the skin that are under pressure). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/7/2025 at 9:06 AM in front of Resident 1 ' s room, treatment nurse (TN 2) was observed preparing medications for Resident 1. The Santyl ointment was observed without a label to indicate who the medication was for, how to administer the medication, the amount of medication to administer, and when the medication should be administered. During an interview on 3/7/2025 at 9:28 AM with TN1, TN 1 stated Resident 1 ' s Santyl ointment label fell off, which was why the Santyl ointment was unlabeled. TN 1 also stated it was important for residents ' medication to be labeled to ensure it was intended for that specific resident and to indicate the directions for use for that specific resident ' s medication. 2. During a concurrent observation and interview on 3/7/2025 at 4:05 PM with license vocational nurse (LVN 4), LVN 4 stated med cart 1 was unlocked, and that the medication cart was left unattended. During an interview on 3/8/2025 at 3:52 PM with LVN 3, LVN 3 stated med carts were supposed to be locked for safety, to prevent residents from opening the med cart and ingesting other residents medications. During an interview on 3/8/2025 at 6:31 PM with the Director of Nursing (DON), the DON stated all medications should be labeled, to indicate which resident the medication was prescribed to. The DON also stated med carts should be locked all the time, and when the med cart was unlocked, any unauthorized individual could have access to the med cart. During a review of facility ' s Policies and Procedures (P&P) titled, Labeling of Medication Containers dated 4/2019, the P&P indicated All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. P&P also indicated labels for individual resident medications include all necessary information such as: a. The resident ' s name b. The prescribing physicians name c. The name, address and telephone number of the issuing pharmacy d. The name strength and quality of the drug e. Prescription # if applicable. f. The date the medication was dispense g. Appropriate accessory and cautionary statements h. The expiration date and when applicable i. Direction for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s P&P titled, Security of Medication Cart dated 4/2007, the P&P indicated the medication cart shall be secure during medication passes. The P&P also indicated the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. Medication cart must be securely locked at all times when out of nurses ' view.