| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555338 | A. Building<br>B. Wing | 03/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brighton Care Center | 1836 N. Fair Oaks Ave<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223<br><br>Based on interview and record review, the facility failed to revise the care plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) for one (1) of two sampled residents (Resident 1) who was at risk for falls by failing to ensure Resident 1's Care Plan for High risk for falls was revised on 3/4/2025 to reflect the Physical Therapy (PT - healthcare profession that focuses on promoting, maintaining, or restoring health through patient education, physical intervention, disease prevention, and health promotion) Recertification (PTR - documentation to ensure continued PT is necessary by documenting progress, justifying medical necessity) note to increase assistance to the resident to perform task and caregiver supervision to decrease fall risk.<br><br>This deficient practice has the potential for Resident 1 to have further falls, which could result in harm, hospitalization , and/or death.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of dizziness and giddiness, muscle wasting and difficulty walking.<br><br>During a review of Resident 1's Fall Risk Assessment, dated 1/30/2025, the assessment indicated resident was at high risk for falls.<br><br>During a review of Resident 1's MDS, dated [DATE], the MDS indicated resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated resident required supervision/touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, sit to stand, chair/bed to chair transfer and walk 10 feet.<br><br>During a review of Resident 1's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/13/2025, the SBAR indicated resident had an unwitnessed fall (first fall in the facility).<br><br>(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: 555338 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/26/2025 |
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| 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) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's SBAR, dated 2/28/2025, the SBAR indicated Resident 1 had an unwitnessed fall (second fall in the facility). The SBAR indicated Registered Nurse Supervisor (not specified who) assisted the resident to the room, locked the wheelchair and exited the room. The SBAR also indicated when the Registered Nurse Supervisor came back, the resident was on the floor near the bedside.<br><br>During a review of Resident 1's Care Plan with focus High risk for falls, initiated on 2/28/2025, the Care Plan indicated goals of the resident will be free of falls and the resident will not sustain serious injury. The Care Plan also indicated interventions included: educate the resident about safety reminders. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>During a review of Resident 1's Care Plan with focus on Resident had an actual fall on 2/28/2025, initiated on 2/28/2025, indicated the resident had an actual fall on 2/28/2025 due to confusion, generalized weakness and poor safety awareness. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>During a review of Resident 1's PTR dated 3/4/2025, the PTR indicated, the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>During a review of Resident 1's SBAR, dated 3/11/2025, the SBAR indicated Resident 1 had an unwitnessed fall (third fall in the facility). The SBAR indicated Certified Nursing Assistant (CNA) assisted and setup Resident 1's breakfast tray, then proceeded to another resident while leaving Resident 1 unsupervised.<br><br>During the same interview and record review with the DON on 3/25/2025 at 3pm, Resident 1's Care Plan for high risk for fall, dated 2/28/2025, and Care Plan for Actual Fall dated 2/28/2025 were reviewed. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk. The DON stated the care plan was not revised on 3/4/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk per PTR notes. The DON also stated the care plan should focus on the issues which would be addressed in the interventions, such as the resident requiring supervision while eating due to poor safety judgment.<br><br>During a concurrent record review and interview on 3/26/2026 at 11:02 AM, Resident 1's PTR, dated 3/4/2025 was reviewed. The PTR indicated Resident 1 has poor safety awareness resulting in falls and required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk. DOR stated poor safety, and judgment was the number one cause to Resident 1's fall. DOR also stated if Resident 1 had supervision last 3/11/2025 during breakfast, the resident's fall could have been prevented. DOR stated the resident's care plan should have been revised to reflect the supervision the resident needed.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, revised March 2018, the P&P indicated the facility will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls.<br><br>(continued on next page) |

| 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 03/26/2025 |
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| 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.

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, revised March 2022, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P also indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223<br><br>Based on interview and record review, the facility failed to ensure two of two sampled residents (Residents 1 and 2) were free from falls and injury by failing to:<br><br>1.a Ensure Certified Nursing Assistant 2 (CNA 2) did not leave Resident 1 who was assessed to require increased assistance to perform tasks and the resident would benefit from caregiver (facility staff) supervision to decrease fall risk, without facility staff to supervise Resident 1 in the resident's room while the resident is sitting in a wheelchair during breakfast on 3/11/2025 in accordance with Resident 1's Physical Therapy (PT - healthcare profession that focuses on promoting, maintaining, or restoring health through patient education, physical intervention, disease prevention, and health promotion) Recertification (PTR - documentation to ensure continued PT is necessary by documenting progress, justifying medical necessity).<br><br>1.b Ensure facility staff provided supervision to Resident 1 while the resident is eating breakfast on 3/11/2025 in accordance with the resident's Minimum Data Set (MDS - a resident assessment tool).<br><br>1.c Ensure Resident 1's Care Plan for high risk for fall was resident centered and was revised on 3/4/2025 to reflect the PTR's note to increase assistance to the resident to perform task and caregiver supervision to decrease fall risk.<br><br>2.a Ensure Licensed Vocational Nurse 1 (LVN 1) did not leave Resident 2 who was assessed to have poor (unable to maintain a sitting balance) static sitting balance (body remains stationary while sitting) and required supervision, without facility staff to supervise Resident 2 in his room while the resident is sitting on the side of the bed during dinner ( while eating) on 3/10/2025 in accordance with Resident 2's Physical Therapy Certification (PTC - documentation to justify medical necessity for PT services) and Physical Therapy Recertification).<br><br>2.b Ensure facility staff provided supervision to Resident 2 while the resident is eating dinner on 3/10/2025 in accordance with the resident's (MDS - a resident assessment tool).<br><br>2.c Ensure Resident 2's Care Plan for At risk for falls was resident centered care plan to include the intervention to supervise the resident while in a sitting position per resident's PTC.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | These deficient practices resulted in Resident 1 being found on the floor pad (a piece of thick, soft material designed to cushion the impact of a fall) on 3/11/2025 around 7:30 AM and was complaining of pain on the right side of the rib cage (a bony structure in the chest that protects vital organs like the heart and lungs and facilitates breathing). Resident 1 had an X-ray (used to generate images of tissues and structures inside the body) of the right ribs on 3/11/2025 due to chest pain and result indicated an acute hairline fracture (tiny cracks in the bone) at fourth and fifth ribs near rib angle (the part where the rib takes a sharp bend, also known as the costal angle, which allows for rib expansion and contraction during breathing). Resident 1 was sent to General Acute Care Hospital (GACH) 2 on 3/11/2025 and was discharged to home from GACH 2 on 3/14/2025 with hospice care services (specialized medical care focused on providing comfort, no treatment of injuries or disease, and support for individuals with a life expectancy of six months or less). In addition, these deficient practices resulted in Resident 2 being found on the floor pad, unable to move his right lower extremity (right leg) on 3/10/2025 around 6:50 PM.<br><br>Findings:<br><br>1. During a review of Resident 1's Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of dizziness and giddiness, muscle wasting and difficulty walking.<br><br>During a review of Resident 1's Fall Risk Assessment, dated 1/30/2025, the assessment indicated resident was at high risk for falls.<br><br>During a review of Resident 1's MDS, dated [DATE], the MDS indicated resident was moderately impaired in cognitive skills (the ability to understand and make decisions) for daily decision making. The MDS also indicated resident required supervision/touching assistance with eating and substantial/maximal assistance with oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, sit to stand, chair/bed to chair transfer and walk 10 feet.<br><br>During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/13/2025, the SBAR indicated resident had an unwitnessed fall (first fall in the facility).<br><br>During a review of Resident 1's SBAR, dated 2/28/2025, the SBAR indicated Resident 1 had an unwitnessed fall (second fall in the facility). The SBAR indicated Registered Nurse Supervisor (not specified who) assisted the resident to the room, locked Resident 1's wheelchair and exited the room. The SBAR also indicated when the Registered Nurse Supervisor came back, the resident was on the floor near the bedside.<br><br>During a review of Resident 1's Care Plan with focus High risk for falls, initiated on 2/28/2025, the Care Plan indicated goals of the resident will be free of falls and the resident will not sustain serious injury. The Care Plan also indicated interventions included: educate the resident about safety reminders. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Care Plan with focus on Resident had an actual fall on 2/28/2025, initiated on 2/28/2025, indicated the resident had an actual fall on 2/28/2025 due to confusion, generalized weakness and poor safety awareness. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>During a review of Resident 1's PTR dated 3/4/2025, the PTR indicated, the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk.<br><br>During a review of Resident 1's SBAR, dated 3/11/2025, the SBAR indicated Resident 1 had an unwitnessed fall (third fall in the facility).<br><br>During a review of Resident 1's Progress Notes, dated 3/11/2025 at 8 AM, the Progress Notes indicated resident had an unwitnessed fall and was found on top of a floor pad and resident had pain on the right rib cage. The Progress Notes indicated doctor ordered stat (immediately) X-ray of the right rib cage.<br><br>During a review of Resident 1's Progress Notes, dated 3/11/2025 at 10:38 PM, the notes indicated a call was made to Resident 1's emergency contact to inform of the resident's X-ray result and doctor ordered for resident to be transferred to GACH.<br><br>During a review of Resident 1's Radiology (branch of medicine that uses imaging technology to diagnose and treat disease. Example is X-ray) Result Report (done in the facility), dated 3/12/2025, the report indicated Resident 1 had an X-ray of the right rib cage on 3/11/2025 and the result showed acute hairline fractures at fourth and fifth right ribs near rib angle.<br><br>During a review of Resident 1's Progress Notes, dated 3/12/20205 at 10:51 AM, the notes indicated transportation arrived at facility to transfer resident to GACH 2.<br><br>During a review of Resident 1's MAR, dated 3/2025, the MAR indicated Resident 1 was given acetaminophen on 3/11/2025 at 8:42 AM resident's pain level of 3/10 and on 3/12/2025 at 9:01 AM for resident's pain level of 3/10.<br><br>During a review of Resident 1's GACH 2's Physician Daily Progress Notes, dated 3/15/2025 at 7:41 AM, the GACH 2's Physician Daily Progress Notes indicated resident was discharged home with hospice care.<br><br>During an interview on 3/24/2025 at 11:44 AM, CNA 2 stated on 3/11/2025 at 7:15 AM, CNA 2 placed resident in a wheelchair and gave the resident her breakfast tray on top of the resident's bedside table. CNA 2 also stated after CNA 2 gave the resident the breakfast tray, CNA 2 left the resident's room without other facility staff to supervise the resident while the resident is eating (unable to recall what time). In addition, CNA 2 stated when CNA 2 came back to the resident's room around 7:30 AM, Resident 1 was found on the floor.<br><br>During an interview on 3/24/2025 at 12:41 PM, LVN 2 stated on 3/11/2025 after Resident 1's fall, the resident told LVN 2 that the resident's rib was hurting.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 3/24/2025 at 1:08 PM, RN 2 stated on 3/11/2025 around 7:45 AM, she was called to Resident 1's room when the resident was found sitting on the floor pad.<br><br>During a concurrent record review and interview on 3/25/2024 at 10:38 AM, Resident 1's MDS, dated [DATE] was reviewed. The MDS indicated Resident 1 required supervision/touching assistance with eating. MDS Nurse stated Resident 1 required supervision/touching assistance when eating and facility staff should be present while Resident 1 is eating.<br><br>During an interview on 3/25/2025 at 3 PM, the Director of Nursing (DON) stated it is not okay to have Resident 1 sit by herself because the resident required supervision while in a sitting position and during mealtime/ while the resident is eating. The DON also stated supervision/touching assistance means facility staff need to be present and supervise Resident 1 while eating.<br><br>During the same interview and record review with the DON on 3/25/2025 at 3pm, Resident 1's Care Plan for high risk for fall, dated 2/28/2025, and Care Plan for Actual Fall dated 2/28/2025 were reviewed. The Care Plan did not indicate it was revised from 3/4/2025 to 3/11/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk. The DON stated the care plan was not revised on 3/4/2025 to reflect that the resident required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk per PTR notes. The DON also stated the care plan should focus on the issues which would be addressed in the interventions, such as the resident requiring supervision while eating due to poor safety judgment.<br><br>During a concurrent record review and interview on 3/26/2026 at 11:02 AM, Resident 1's PTR, dated 3/4/2025 was reviewed. The PTR indicated Resident 1 has poor safety awareness resulting in falls and required increased assistance to perform tasks and would benefit from supervision in order to decrease fall risk. DOR stated poor safety, and judgment was the number one cause to Resident 1's fall. DOR also stated if Resident 1 had supervision last 3/11/2025 during breakfast, the resident's fall could have been prevented. DOR stated Resident 1 would always require assistance.<br><br>During a concurrent record review and interview on 3/26/2025 at 11:02 PM, Resident 1's Occupational Therapy (OT - a branch of health care that helps people of all ages who have physical, sensory, or cognitive problems) Recertification (OTR), dated 3/4/2025 was reviewed. OTR indicated the resident has poor safety awareness, continued problems in functional mobility, continued problems in Activities of Daily Living (ADL- includes eating) and continued problems in weakness. DOR stated, per Resident 1's OTR the resident's safety is a concern while the resident is in wheelchair and the resident would need supervision to prevent falls. DOR also stated Resident 1 needs moderate assistance in the wheelchair.<br><br>2. During a review of Resident 2's Admission Record, the Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnosis of muscle weakness.<br><br>During a review of Resident 2's Fall Risk Assessment, dated 2/10/2025, the assessment indicated Resident 2 was at low risk for falls.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 2's MDS, dated [DATE], the MDS indicated resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating. Resident 2 also required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer.<br><br>During a review of Resident 2's Care Plan with focus, At risk for falls, initiated 2/18/2025, indicated resident has cognitive impairment, poor safety judgement, awareness, confusion and forgetfulness. The Care Plan also indicated the goal to minimize risk of fall and injury, and interventions included: bed or chair alarm (a device used in health care setting to warn caregivers when residents leave or attempt to leave their bed/chair) and remind the resident to call for assistance and not to get out of bed without assistance.<br><br>During a review of Resident 2's SBAR, dated 3/10/2025, the SBAR indicated unwitnessed fall due to overestimating (overcalculating or doing more than he can/ or is able to) his (Resident 2's) capacity.<br><br>During a review of Resident 2's Progress Notes, dated 3/10/2025 at 6:50 PM, the Progress Notes indicated Resident 2 was on the floor mat (floor pad). The Progress Notes also indicated Resident 2 was unable to move his right lower extremity.<br><br>During a review of Resident 2's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2025, the MAR indicated on 3/10/2025 at 7:50 PM Resident 2 was given acetaminophen (pain medication) as needed for the resident's pain level of 3/10 (10 as the most painful).<br><br>During a review of Resident 2's Progress Notes, dated 3/10/2025 11:27 PM, indicated Resident 2's right hip X-ray was done and awaiting results.<br><br>During a review of Resident 2's Progress Notes, dated 3/11/2025 at 8:31 AM, indicated resident X-ray result showed an acute (sudden), mildly displaced fracture (the bone has broken into two or more pieces, but the broken ends are slightly out of alignment, requiring medical intervention to realign them for proper healing, but not necessarily surgery) of the neck (the narrow, flattened part of the femur [the long bone located in the thigh, extending from the hip to the knee, and is the longest and strongest bone in the human body] bone that connects the femoral head (ball of the hip joint) to the femoral shaft) of the right femur. The Progress Notes also indicated the doctor ordered to transfer Resident 2 to GACH 1 for further evaluation.<br><br>During a review of Resident 2's Resident Transfer Record, dated 3/11/2025, the record indicated Resident 2 will be transferred to GACH for abnormal right hip X-ray result.<br><br>(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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 2's GACH 's 1 discharge summary note, dated 3/21/2025, the GACH discharge summary note indicated Resident 2 was admitted at the GACH 2 on 3/11/2025 and the resident had a right femoral neck fracture. The GACH 2 discharge summary note also indicated Resident 2 was discharged back to the facility on [DATE] with instruction to outpatient follow up for elective hemiarthroplasty (partial hip replacement, involves replacing only the femoral head (the ball of the hip joint) with a prosthetic (artificial body part), leaving the acetabulum (the hip socket) intact, and is often used to treat hip fractures, especially in elderly patients).<br><br>During an interview on 3/24/2025 at 3:04 PM, Licensed Vocational Nurse 1 (LVN 1) stated when Resident 2 came back from dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and LVN 1 assisted Resident 2 to sit on the side of Resident 2's bed, gave the resident his dinner and left the resident unsupervised by facility staff on 3/10/2025 at 5:20 PM inside the resident's room.<br><br>During a concurrent record review of Resident 2's MDS, dated [DATE], and interview on 3/25/2025 at 10:38 AM, the MDS indicated Resident 2 required supervision or touching assistance with eating. The MDS nurse stated Resident 2 required someone to be present based on the resident needing to be supervised eating and, in the event, the resident gets up on his own.<br><br>During a concurrent record review and interview on 3/25/2025 at 3 PM, Resident 2's Fall Care Plan for At Risk for fall, dated 2/18/2025 to 3/10/2025, the Care Plan indicated intervention is to place bed or chair alarm and remind the resident to call for assistance and not to get out of bed without assistance. The DON stated the care plan was not resident centered as the intervention included to remind the resident to call for assistance and not to get out of bed without assistance. The DON stated this intervention would not be effective for Resident 2 as the resident is severely impaired with his cognitive skills. The DON also stated, the care plan did not indicate intervention to supervise the resident while in a sitting position to reflect what was the recommendation in Resident 1's PTC note done on 2/11/2025.<br><br>During an interview on 3/25/2025 at 3 PM, the Director of Nursing (DON) stated it is not okay to have Resident 2 sit by himself on the edge of the bed because Resident 2 required supervision while eating per the resident's MDS. The DON also stated supervision/touching assistance means a person had to be there and a staff cannot give Resident 2 his food and leave the resident unsupervised while the resident is eating.<br><br>During a concurrent interview and record review of Resident 2's PTC, dated 2/11/2025, the PTC indicated resident has poor safety awareness and judgment noted and required supervision. The PTC indicated static sitting balance was poor and is not able to be corrected. The PTC indicated dynamic sitting balance (the ability to maintain stability and control while sitting) was poor (able to sit unsupported with moderate assistance). DOR stated, per Resident 2's PTC, the resident needs to be supervised and cannot be left alone by facility staff when in a sitting position because the resident can lose balance and fall. DOR stated if Resident 2 has someone there to assist/ supervise the resident on 3/10/2025 then the fall could have been prevented.<br><br>(continued on next page) |

| 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 03/26/2025 |
|---|---|---|---|
| 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.

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the facility's Policy and Procedure (P&P), titled Safety and Supervision of Residents, revised 7/2017, the P&P indicated resident safety and supervision and assistance to prevent accidents are facility wide priorities. The P&P also indicated resident supervision is a core component of the systems approach to safety and the type and frequency of resident supervision is determined by the individual resident assessed needs and identified hazards in the environment.<br><br>During a review of the facility's P&P, titled Accident and Resident Safety Reporting, revised 11/21/17, the P&P indicated each resident receives adequate supervision and assistive devices to prevent accidents. The P&P also indicated to provide an environment that is free as possible from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.<br><br>During a review of the facility's P&P, titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. |