

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  04/04/2025
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.

(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48152</p> <p>Based on interview and record review, the facility failed to develop a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs) per facility policy, for one of four sampled residents (Resident 2).</p> <p>These failures had the potential for Resident 2 to receive colostomy care that is not personalized to meet the specific needs identified above, which could result in decreased quality of care and quality of life.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included colostomy status, malignant neoplasm of colon and abscess (a collection of pus) of intestine.</p> <p>During a review of Resident 2 ' s discharge Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2025, the MDS indicated Resident 2 has intact cognitive skills. The MDS indicated Resident 2 was partial moderate assistance for toileting hygiene, bathing, lower body dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating, oral and personal hygiene.</p> <p>During a review of Resident 2 ' s Body/Skin Assessment, dated 3/26/2025, the Assessment indicated Resident 2 had a colostomy site on the abdomen.</p> <p>During a review of Resident 2 ' s Order Summary Report, dated 4/3/2025, the Order Summary Report indicated an order for colostomy placement on 3/17/2025. The Order Summary Report also indicated a treatment order to cleanse the colostomy site with normal saline (NS- a saltwater solution), pat dry and apply colostomy bag every dayshift, ordered on 3/26/2025.</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 interview and record review on 4/3/2025 at 1:53PM with Treatment Nurse 1 (TN 1), Resident 2 ' s medical chart dated from 3/25/2025 to 4/3/2025 was reviewed. Resident 2 ' s chart did not indicate a care plan for Resident 2 ' s colostomy. TN 1 states there is no developed care plan to address Resident 2 ' s colostomy and there should have been. TN 1 stated there should be a care plan so that staff know what nursing interventions to provide including monitoring the stoma site for signs/symptoms of infection, the treatments to provide and the need to monitor any pain during treatment and the goals of care. TN 1 also stated a care plan was needed for staff to follow and know how to provide care to the colostomy.</p> <p>During an interview of 4/3/2025 at 3:54PM with Registered Nurse Supervisor (RNS), RNS stated care plans are a way to individualize each resident ' s needs, any interventions and accommodations to the resident needs and their goals. RNS stated care plans provide a way for staff to see the goals and needed interventions for residents and that there should have been a care plan created for Resident 2 ' s colostomy. RNS also stated Resident 2 needed a care plan because the colostomy needs interventions such as monitoring for any signs and symptoms of draining, vital signs, stool consistency. RNS stated not having a care plan could slow down his progress to healing and discharging home.</p> <p>During an interview on 4/4/2025 at 2:43PM with the DON, the DON stated care plans are necessary for the delivery of care to ensure everyone knows the resident ' s goals and care interventions. The DON stated not having a care plan for the residents means there may be a lapse in the continuity of care being given and the overall care and picture of the resident may not be accurate without a care plan.</p> <p>During a review of the facility ' s Policy &amp; Procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&amp;P indicated the comprehensive, person-centered care plan:</p> <ul style="list-style-type: none"> <li>&gt; Includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</li> <li>&gt; Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, care plans are revised as information about the residents and the residents' conditions change.</li> <li>&gt; Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.</li> <li>&gt; Include the Resident ' s stated goals upon admission and desired outcomes.</li> </ul>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48152</p> <p>Based on observation, interview and record review, the facility failed to provide colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) care for one of four sampled residents (Resident 2) as ordered by the physician.</p> <p>This failure had the potential to result in colostomy complications including discomfort, stool leakage or decreased quality of life for Resident 2.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included colostomy status, malignant neoplasm (a cancerous tumor) of colon (the large intestine) and abscess (a collection of pus) of intestine.</p> <p>During a review of Resident 2 ' s Discharge Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2025, the MDS indicated Resident 2 has intact cognitive skills. The MDS indicated Resident 2 was partial moderate assistance for toileting hygiene, bathing, lower body dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating, oral and personal hygiene.</p> <p>During a review of Resident 2 ' s Body/Skin Assessment, dated 3/26/2025, the Assessment indicated Resident 2 had a colostomy site on the abdomen.</p> <p>During a review of Resident 2 ' s Order Summary Report, dated 4/3/2025, the Order Summary Report indicated an order to cleanse the colostomy site with normal saline (NS- a saltwater solution), pat dry and apply colostomy bag (a pouch that collects waste from the body) every dayshift, ordered 3/26/2025.</p> <p>During an observation and interview on 4/3/2025 at 11:23 AM with Treatment Nurse 1 (TN 1) at Resident 2 ' s bedside, TN 2 was observed emptying Resident 2 ' s colostomy bag. TN 2 failed to cleanse the colostomy site with NS, pat dry and apply a colostomy bag. TN 1 stated she emptied Resident 2 ' s colostomy bag only.</p> <p>During a concurrent interview and record review on 4/3/2025 and 1:53 PM with TN 1, Resident 2 ' s medical chart dated from 3/25/2025 to 4/3/2025 was reviewed. The medical record failed to indicate any refusal colostomy care and/or physician notification of treatment refusal regarding colostomy care. TN 1 stated the last time Resident 2 ' s colostomy care was given as ordered was on 4/2/2025 and the care was not provided because Resident 2 ' s Family Member (FM) instructed her to empty the colostomy bag only. TN 2 stated she did not document the refusal of colostomy care because she forgot. TN 2 stated it is important to give treatments as ordered because the orders tell what care the resident needs.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/4/2025 at 2:08PM with the Director of Nursing (DON), the DON stated per the current physician order for Resident 2, the colostomy site is to be cleaned, pat dried and colostomy bag changed every day and if resident refuses, there should be documentation in the medical record indicating the resident refused, the physician was notified and a care plan created regarding the resident ' s refusal of treatment.</p> <p>During an interview on 4/4/2025 at 2:43PM with the DON, the DON stated it is important to give treatments as ordered because it is a need for the patient and staff are to make sure that every treatment is provided to the residents.</p> <p>During a review of the facility ' s Policy &amp; Procedure (P&amp;P) titled, Colostomy and Ileostomy (a surgical procedure that brings one end of the small intestine out through the abdominal wall to allow waste to leave the body) Care, (undated), the P&amp;P indicated:</p> <p>The policy purpose is for providing safe, effective and compassionate care for residents with colostomies or ileostomies at the facility.</p> <p>a. Proper care of colostomies and ileostomies is essential for the well-being and comfort of the resident, minimizing complications, promoting independence and improving quality of life.</p> <p>b. Colostomy and ileostomy care will be provided to residents requiring ostomy care unless contraindicated by the physician.</p> <p>c. Licensed Vocational Nurses (LVNs) perform colostomy/ostomy care including pouch changing, cleaning the stoma and evaluating the surrounding skin for any irritation.</p> <p>d. Report any concerns related to ostomy care to attending physician or specialist.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48152</p> <p>Based on observation, interview and record review, the facility failed to ensure the colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) care was documented accurately and completely for one of two sampled residents (Resident 2), as indicated in the facility's policy titled, Charting and Documentation,.</p> <p>This failure had the potential to negatively impact the delivery of treatments and care for Resident 2's colostomy.</p> <p><b>FINDINGS:</b></p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included colostomy status, malignant neoplasm (a cancerous tumor) of colon (the large intestine) and abscess (a collection of pus) of intestine.</p> <p>During a review of Resident 2's Minimum Data Set (MDS -a resident assessment tool), dated 3/17/2025, the MDS indicated Resident 2 has intact cognitive skills (ability to understand and make decisions). The MDS indicated Resident 2 was partial moderate assistance (helper does less than half the effort needed to complete the activity) for toileting hygiene (includes wiping the opening of an ostomy (an artificial opening in an organ of the body) bathing, lower body dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating, oral and personal hygiene.</p> <p>During a review of Resident 2's Body/Skin Assessment, dated 3/26/2025, the Assessment indicated Resident 2 had a colostomy site on the abdomen.</p> <p>During a review of Resident 2's Order Summary Report, dated 3/13/2025, the Order Summary Report indicated an order to cleanse the colostomy site with normal saline (NS- a saltwater solution), pat dry and apply colostomy bag (a pouch that collects waste from the body) every dayshift, ordered on 3/26/2025.</p> <p>During a review of Resident 2's Treatment Administration Record (TAR), dated 4/1/2025 to 4/30/2025, the TAR indicated a treatment to Resident 2's colostomy site: cleanse with NS, pat dry, apply colostomy bag ever dayshift.</p> <p>During an observation on 4/3/2025 at 11:23AM with Treatment Nurse 1 (TN 1) at Resident 2's bedside, TN 1 was observed emptying the colostomy bag for Resident 2. TN 1 was not observed providing colostomy site cleansing with NS, and/ or replacing Resident 1's the colostomy bag.</p> <p>During an interview on 4/3/2025 at 1:53PM with Treatment Nurse 1 (TN 1), TN 1 stated she did not change Resident 2's colostomy bag, and did not clean the colostomy site during the shift because Family Member 1 told TN 1 to only empty the colostomy bag. TN 1 also stated she did not document or sign Resident 2's TAR for 4/3/2025 indicating the care had been administered.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/3/2025 at 2:44PM at with TN 2, Resident 2's Treatment Administration Record (TAR), dated 4/3/2025, was reviewed. The TAR indicated a treatment to Resident 2's colostomy site: cleanse with NS, pat dry, apply colostomy bag was signed and administered by TN 2. TN 2 stated he did not provide treatment/ cleaning of Resident 2's colostomy site or replacing Resident 2's colostomy bag but documented it was administered. TN 2 stated he should have not documented on Resident 2's TAR colostomy site care was done because he did not provide the care and was not present to ensure it was provided to Resident 2 before signing the TAR. TN 2 stated the documentation was not accurate and it is important to make sure only provided treatments are documented as done and documented by the staff that administered the care or treatment.</p> <p>During an interview on 4/3/2025 at 3:54PM with the Registered Nurse Supervisor (RNS), RNS stated per facility policy, whichever staff provides the treatment or providing medications, that nurse should be logging into their own name and documenting it. The RNS also stated that documentation needs to be accurate to prevent any further errors and/or any further decline and progress of his overall health.</p> <p>During an interview on 4/4/2025 at 2:08PM with the Director of Nursing (DON), the DON stated per the facility's policy, the treatment should be provided and once completed, the nurse that rendered the care then documents and signs on the TAR, unless care not provided and then a progress note would be required.</p> <p>During a review of the facility's Policy &amp; Procedure (P&amp;P) titled, Charting and Documentation, revised 7/2017, the P&amp;P indicated:</p> <ol style="list-style-type: none"> <li>1. All services provided to the resident, progress toward the care plan goal, or changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.</li> <li>2. Documentation in the medical record will be objective, complete and accurate.</li> <li>3. Documentation of procedures and treatments will include care specific details including the date and time the procedure/treatment was provided, the name and title of the individual(s) who provided care, whether the resident refused the procedure/treatment.</li> </ol>		