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	08/06/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) on 8/4/2025 for one (1) of two (2) sampled residents (Residents 1) within two (2) hour timeframe to the State Survey Agency (SA, where state law provides for jurisdiction in long-term care facilities), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement. This deficient practice had the potential to compromise or impede the protection of Resident 1, which could affect the resident's emotional and mental wellbeing.Findings:During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included right hip fracture (a partial or complete break in the upper part of the thigh bone [femur] where it meets the pelvic bone), right hip hemiarthroplasty (a surgical procedure that replaces the femoral head of the hip with metal component), history of falling, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (trouble falling asleep or staying asleep) During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/26/2025, the MDS indicated Resident 1 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) in toileting hygiene, lower body dressing, putting on and taking off footwear, roll left and right, sit to lying, sit to stand, chair/ bed-to-chair transfer, toilet transfer, walk 10, and 50 feet. During an observation and interview on 8/6/2025 at 6:42 AM, Resident 1 was observed sitting on her bed. Resident 1 stated someone came to her room, came close to her and stared at her on Saturday (8/2/2025) at 6:30 AM. The curtain was surrounding her bed, then one man came in and she was completely nude, and the man saw her nude. Resident 1 stated she should have called the police. Resident 1 was very upset and clenched her fists while telling the story. During an interview on 8/6/2025 at 6:54 AM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 stated a man came into her room and looked at her while she was naked. We should report abuse within 2 hours because we have to make sure that nothing happened to her or someone abused her. We have to prove it to make things clear, because she can be psychologically affected by the incident. During an interview on 8/6/2025 at 7:08 AM, with Licensed Vocational Nurse 2 (LVN2), LVN 2 stated, on Monday night (8/4/2025) Resident 1 said somebody came inside her room and she was naked, and a man looked at her. It was endorsed to me by the previous shift that night. If something was mentioned like that, it should be reported right away to the Registered Nurse Supervisor (RNS) and to the Abuse coordinator. It can be traumatizing to Resident 1. She can suffer and can affect her well-being. During an interview on 8/6/2025 at 7:19 AM, with LVN 2, LVN 2 stated, there was no abuse monitoring that was done on my shift. I did not report allegations of abuse. Resident 1 can continue feeling scared, feeling not safe in the facility. I am not sure if the previous shift reported abuse. I thought they did the report, because when they endorsed it to me, I thought it was being handled. During an interview on 8/6/2025 at 7:54 AM with Director of Nursing (DON), DON stated, Resident 1 went to her appointment on Monday 8/4/2025. We received a call from the medical office. Resident 1 told the Doctor that she does not want to go back to the facility because a man was staring at her in her room. Resident 1 stating a man was staring at her while she was naked Saturday morning (8/2/2025). I did not report it to the survey agency, police department and ombudsman. During a concurrent interview and record review on 8/6/2025 at 8:08 with Administrator (ADM), the facility's policy and procedure (P&P) titled, Elder/ Dependent Adult Abuse, revised 3/22/2024 was reviewed. The P&P indicated the facility will report any reasonable suspicion of a crime against a resident and all alleged violations involving abuse. ADM stated, we did not report it because there was no physical interaction with Resident 1. We did not report the incident to the CDPH, police and Ombudsman. We should have reported it within 2 hours when we were made aware on Monday (8/4/2025). During a concurrent interview and record review on 8/6/2025 at 8:17 AM with DON, the facility's P&P titled, Elder/ Dependent Adult Abuse, revised 3/22/2024 was reviewed. The P&P indicated Report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. DON stated, we did not report to the CDPH, police and Ombudsman. During my interview