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	04/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent accidents (any unexpected or unintentional incident, which results or may result in injury or illness) by failing to ensure shower chair wheels were locked for one (1) of two (2) sampled residents (Resident 1) while using the toilet. These deficient practices have resulted in Resident 1 to fall on 3/11/2026 while the reisdent is using the toilet and had the potential to result in serious injury like fractures (break in bone), intracranial hemorrhage (a life threatening, acute bleeding within the skull, often referred to as brain bleed or brain hemorrhage), prolonged hospitalization, and/ or death.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 3/8/2026 and was readmitted on [DATE] with diagnoses including, but not limited to cerebral infarction (occurs when a blood clot or blockage stops blood from reaching a part of the brain), hemiplegia (total paralysis on one side) and hemiparesis (partial muscular weakness on one side of the body) of the right side of the body, and dysarthria (motor speech disorder caused by muscle weakness or lack of control over the muscles used for speaking) and anarthria (loss of articulate [ability to speak fluently and coherently] speech). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/14/2026, the MDS indicated Resident 1 had intact cognitive skills (mental action or process of acquiring knowledge and understanding through thought, experience and senses) for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, oral and personal hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (Helper lifts or holds trunk or limb and provides more than half the effort) with toileting hygiene, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 1 was dependent with showering/bathing self. During a record review of the Situation, Background, Assessment, and Recommendation (SBAR-a structured four-step communication framework to deliver concise, critical information quickly to ensure safety) dated 3/11/2026, the SBAR indicated Certified Assistant 1 (CNA1) assisted Resident 1 to the toilet. The SBAR indicated CNA 1 notified the Charge Nurse that Resident 1 had fallen in the toilet. The SBAR indicated Resident 1 was seen lying on the resident's right side with shower chair on top of the resident's legs. During a concurrent observation and interview on 4/6/2026 at 2 PM, inside Resident 1's room, Resident 1 was observed sitting in his wheelchair watching television. Resident 1 stated he fell when he was in the toilet (unable to recall specific date). Resident 1 stated he was sitting in a shower chair with wheels and leaned forward to try to clean himself when the shower chair moved and he fell forward and hit his head on the floor. Resident 1 stated he felt the shower chair's wheels move and did not expect that it was not locked when he leaned forward and then fell. During a concurrent interview and record review on 4/6/2026 at 3:55 PM with the Administrator (Adm) and Maintenance Staff (MS), the Maintenance Records for daily, weekly and monthly Environment and Safety Check for March 2026 were reviewed. The safety check indicated visual check on shower and wheelchair brakes, back/seat, sharp objects and wheels. MS stated that when the shower chair (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheels were locked, it should not move. MS stated it the staff locked the shower chair's wheels, and it moved, meaning it was broken but it was not reported to MS. During an interview on 4/7/2026 at 10:50 AM with Certified Nurse Assistant (CNA) 2, CNA 2 stated shower chair wheels should be locked and checked to ensure all locks latched by slightly moving the shower chair back and forth. During an interview on 4/7/2026 at 11:51 AM with CNA 1, CNA 1 stated she helped Resident 1 to the toilet on 3/11/2026 at 10:15 PM, then placed the resident on a shower chair with wheels. CNA 1 stated she locked the front wheels of the shower chair but does not remember if she locked the back wheels of the shower chair. CNA 1 also stated she did not double check if the shower chair's wheels were latched on or securely locked before leaving Resident 1 in the toilet. CNA 1 stated she did not remember to report to the maintenance department if the shower chair was broken since the lock may not have been working. During a concurrent interview and record review on 4/7/2026 at 1:25 PM with the Director of Nursing (DON), the policy and procedures (P&P) titled Activities of Daily Living (ADLs), Supporting, revised March 2018 and P&P titled Fall and Fall Risk, Managing, revised March 2018 and the Fall Risk assessment dated [DATE] were reviewed. The DON stated the P&P for ADLs indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting). The DON stated Resident 1 required substantial to maximum assistance with toileting and Resident 1 should not have been left alone in the toilet. The DON stated if Resident 1 requested to be alone in the toilet, CNA 1 should have explained why the resident cannot be left alone for the resident's safety and to prevent falls. During the same concurrent interview and record review on 4/7/2026 at 1:25 PM with the DON, the DON stated P&P for Managing Falls and Fall risk indicated resident conditions that may contribute to the risk of falls include lower extremity weakness, poor grip strength, and functional impairments. The DON stated according to Resident 1's fall risk assessment, the resident has high risk for fall. The DON stated there is no specific P&P for checking equipment such as shower chair wheels, if wheels locked and is in good working condition before care is provided. The DON stated checking the shower chair wheels to see if it was locked was an expectation from the staff to ensure safety of the residents while using equipment to deliver care. The DON further stated that resident safety was more important than resident's preference, but staff should explain the rationale why to the residents to make the residents understand how their preference would be incorporated to the level of care the resident require.