

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/29/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary respiratory care services for two (2) of three (3) sampled Residents (Residents 102 and 13) reviewed for oxygen (O2, a highly reactive, colorless, odorless gas vital for life) as indicated in the facility policy by failing to:Provide Resident 102 a new humidifier (a device used to add moisture to dry oxygen, reducing irritation in the nose and throat for residents during oxygen therapy) when it was empty on 1/26/2026.Administer Resident 13's oxygen as indicated on the physician's order.These deficient practices have the potential for Residents 102 and 13 to develop respiratory complications associated with oxygen therapy.Findings: 1. During a review of Resident 102's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dependence on supplemental oxygen (a highly reactive, colorless, odorless gas vital for life), chronic respiratory failure (CRF) with hypoxia (a long-term, irreversible, or progressive condition where the lungs cannot adequately oxygenate the blood), dyspnea (a subjective, uncomfortable, or difficult breathing sensation often described as air hunger, chest tightness, or rapid, shallow breathing), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 102's History and Physical (H&P), dated 1/21/2026, the H&P indicated the resident was alert and oriented times four (4) (person, place, time and situation). The H&P also indicated Resident 102 has some dyspnea and to continue oxygen therapy. During a review of Resident 102's Physician Orders, dated 1/22/2026, the Physician Orders indicated to administer oxygen at 3 liters (l &ndash; unit of measure)/ minute via nasal cannula (a lightweight, flexible, medical-grade tube used to deliver supplemental oxygen directly into the nostrils for respiratory support) for shortness of breath (SOB) every shift to maintain oxygen saturation (the percentage of hemoglobin in your red blood cells that is currently carrying oxygen) of 92% and above. Call physician if oxygen saturation is less than 92%. During a concurrent observation in Resident 102's room and interview on 1/26/2026 at 10:03 AM, Resident 102 was observed in bed receiving oxygen via nasal cannula. Resident 102 stated her throat feels dry. Resident 102's oxygen concentrator with an empty humidifier bottle was observed on the left side of the resident's bed. During a concurrent observation and interview on 1/28/2026 at 8:45 AM, the Director of Nursing (DON) stated there should be water in the humidifier bottle so that when Resident 102 receives oxygen, it is not dry. The DON also stated that Resident 102's humidifier bottle was empty. The DON also stated it should not be empty, and that it needed to be changed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the DON and review of the policy on 1/29/2026 at 3PM, the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, was reviewed. The DON stated per policy, the humidifying jar should contain water and that the water level should be high enough for bubbles to form as oxygen flows through while the resident is receiving oxygen. During a review of the facility's P&P titled, Oxygen Administration, revised 10/2010, the P&P indicated check the humidifying jar to be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows throughout. The P&P also indicated the periodically re-check water level in humidifying jar. 2. During a review of Resident 13's admission Record, the admission Record indicated the facility initially admitted Resident 13 on 1/4/2026 and readmitted on [DATE] with diagnoses including, but not limited to COPD and emphysema (a chronic lung disease, usually caused by smoking, where the tiny air sacs [alveoli] in the lungs are damaged and destroyed] causing severe shortness of breath). During a review of Resident 13's Care Plan, the Care Plan, initiated on 1/5/2026 and 1/13/2026, indicated resident was at risk for SOB and ineffective airway exchange/chest congestion related to COPD and emphysema. The staff interventions included continuous O2 at 2L per minute via nasal cannula. During a review of Resident 13's Order Summary dated 1/13/2026, the Order Summary indicated to administer O2 at two (2) L/min via nasal cannula for SOB every shift to maintain O2 saturation at 92% and above and to be initiated by a Registered Nurse (RN) and weekly tubing change and daily humidifier change by a Licensed Vocational Nurse (LVN). During a review of Resident 13's Minimum Data Set (MDS-a resident assessment tool) dated 1/19/2026, the MDS indicated Resident 13 had intact cognitive (ability to think, understand, and reason) skills for daily decision making. The MDS indicated Resident 13 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating. The MDS indicated Resident 13n 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 oral and personal hygiene and upper body dressing. The MDS indicated Resident 13 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 13 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right on the bed, sitting on side of the bed to lying flat on the bed, lying to sitting on side of the bed, sitting in the chair/wheelchair, or on the side of the bed to standing position, chair/bed-to chair transfer and toilet transfer. The MDS indicated Resident 13 was dependent (Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with showering/bathing self and tub/shower transfer. The MDS also indicated Resident 13 was on O2 therapy. During a concurrent observation and interview on 1/26/2026 at 10:04 AM inside Resident 13's room, Resident 13 was sitting in his wheelchair and was on O2 at 3L per minute. Resident 13 stated he used O2 all the time. During a concurrent observation and interview on 1/28/2026 at 4:10 PM with the DON, the order (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for six (6) of 10 sampled residents (Residents 95, 64, 24, 82, 15, and 109) reviewed and observed for medications administration, in accordance with the facility's policy and procedure (P&P) by failing to: 1.Administer metformin (medication used to control high blood sugar levels) and potassium chloride (medication used to regulate the heartbeat) within 60 minutes of the scheduled time of 7:15 AM for Resident 95.This deficient practice had the potential for Resident 95 to experience chest pain, shortness of breath, dizziness, and placed Resident 95 at risk for inadequate blood sugar management which could cause hyperglycemia (elevated blood sugar level).2. Administer metoprolol tartrate (a medication used to treat high blood pressure) within 60 minutes of scheduled time of 7:15 AM for Resident 64.This deficient practice had the potential for Resident 64 to experience high blood pressure and a decline in overall health status.3. Administer Aspirin (a medication used as prophylaxis [action to prevent disease] for cerebrovascular accident [CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]), docusate sodium (a medication used to soften the stool), venlafaxine (Effexor- a medication used to treat major depressive disorder), memantine (Namenda- a medication used to treat moderate to severe dementia), and Vitamin D3 (a supplement for immune, muscle, and bone health) within 60 minutes of scheduled time of 9 AM for Resident 24.This deficient practice had the potential for a decline in Resident 24's overall health status and decrease the therapeutic levels of Resident 24's memantine and namenda which could cause Resident 24's dementia and depression symptoms to worsen or not be properly managed.4. Administer prednisone (medication used to suppress the body's immune response and inflammation in the lungs) within 60 minutes of scheduled time of 7:15 AM for Resident 82.This deficient practice had the potential for Resident 82 to experience shortness of breath and chronic obstructive pulmonary disease (COPD- a long term lung disease causing difficulty breathing) exacerbation (a sudden, significant worsening of a pre-existing disease where symptoms become more severe and may require a change in treatment or emergency care).5. and 6. Sign the narcotic (medication that dulls the senses, produces pain relief, and can cause sleep) sheet after Residents 15 and 109 were administered narcotic medication.This deficient practice had the potential of under or overdosing Resident 15 and 109 with narcotics or potential for drug diversion (illegal or unauthorized transfer of prescription medications-especially controlled substances-from the person for whom they were prescribed to someone else for misuse, abuse, or sale).Findings: 1.During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that begins and ends suddenly with episodes lasting not more than seven days), nonrheumatic mitral valve insufficiency (a leaky heart valve on the left side that does not close properly, allowing blood to flow backward into the heart), and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 95's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 95 was assessed having moderately impaired memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 95 required setup or clean-up assistance with eating, upper body dressing, and rolling left and right. The MDS indicated Resident 95 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower/bathe self, and putting on/taking off footwear. During a review of Resident 95's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications: Metformin HCl 1000 milligrams (mg-unit of measurement), give 1 tablet by mouth one time a day for DM, ordered on 10/8/2025. Potassium chloride 20 milliequivalent (mEq- unit of measurement), give 1 tablet by mouth one time a day for hypokalemia, ordered on 7/30/2025. During a review of Resident 95's Medication Administration Record (MAR), from 1/1/2026 to 1/31/2026, the MAR indicated Resident 95 was scheduled to receive the following medications at 7:15 AM: Metformin HCl 1000 mg Potassium chloride 20 mEq During an observation of the medication pass on 1/28/2026, at 8:55 AM, Licensed Vocational Nurse 1 (LVN 1) administered the following medications to Resident 95: Metformin HCl 1000 mg, 1 tablet by mouth Potassium chloride 20 mEq, 1 tablet by mouth 2.During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential hypertension (HTN- high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and depression (a treatable mood disorder characterized by persistent sadness, loss of interest in activities and feelings of hopelessness). During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 64 required partial/moderate assistance upper body dressing, sit to stand, toilet transfer, and tub/shower transfer. The MDS indicated Resident 64 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 64's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order, ordered on 9/5/2025, for metoprolol tartrate, give 12.5 (1/2 tab of 25 mg tablet) mg by mouth two times a day for HTN, hold for systolic blood pressure (SBP- pressure in the arteries when the heart contracts and pumps blood out) less than 110 or heart rate (HR) less than 60. During a review of Resident 64's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 64 was scheduled to receive metoprolol tartrate 12.5 mg at 7:15 AM. During an observation of the medication pass on 1/28/2026, at 9:12 AM, LVN 1 administered metoprolol tartrate 12.5 mg, 1/2 tablet by mouth to Resident 64. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2026, at 9:13 AM, with LVN 1, LVN 1 stated Resident 64's metoprolol was scheduled to be given at 7:15 AM. LVN 1 stated the facility staff were allowed to administer medications two (2) hours before and 2 hours after the scheduled medication time. 3. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (a brain disorder that results in memory loss, poor judgment, and confusion), major depressive disorder (depression), and essential hypertension. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 24 required supervision or touching assistance with eating, oral/toileting/personal hygiene, upper body dressing, and sit to lying. The MDS indicated Resident 24 required substantial/maximal assistance with shower/bathe self, lower body dressing, putting on/taking off footwear, sit to stand, and toilet transfer. During a review of Resident 24's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications: Aspirin tablet chewable 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients) prophylaxis (action to prevent disease), ordered on 9/26/2025. Docusate sodium 100 mg, give 200 mg (2 tabs) by mouth one time a day for bowel management, hold for loose stools, ordered on 6/12/2025. Effexor XR oral capsule extended release 24-hour 75 mg (venlafaxine HCl), give 1 capsule by mouth one time a day for major depressive disorder, ordered on 9/26/2025. Namenda tablet 5 mg (memantine HCl), give 1 tablet by mouth two times a day for dementia, ordered on 6/22/2021. Vitamin D3 (cholecalciferol) 1000 IU, give 2000 IU (2 tabs) by mouth one time a day for Vitamin D deficiency, ordered on 9/26/2025. During a review of Resident 24's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 24 was scheduled to receive the following medications at 9 AM: Aspirin tablet chewable 81 mg Docusate sodium 200 mg. Effexor XR oral capsule extended release 75 mg Namenda tablet (memantine HCl) 5 mg Vitamin D3 (cholecalciferol) 2000 IU During an observation of the medication pass on 1/28/2026, at 10:24 AM, LVN 1 administered the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following medications to Resident 24: Aspirin tablet chewable 81 mg, 1 tablet by mouth Docusate sodium 100 mg, 2 tablets by mouth Effexor XR 75 mg (venlafaxine HCl), 1 capsule by mouth Namenda tablet 5 mg (memantine HCl), 1 tablet by mouth Vitamin D3 (cholecalciferol) 1000 IU, 2 tabs by mouth During a concurrent interview and record review on 1/28/2026, at 4:15 PM, with LVN 1, Residents 95, 64, and 24's MARs were reviewed. LVN 1 stated the following medications were not administered within 60 minutes of their scheduled time: Residents 95's potassium chloride, and metformin medications. Resident 64's metoprolol medication. Resident 24's Aspirin, docusate sodium, venlafaxine, memantine, and vitamin D3 medications. During a follow up interview on 1/28/2026, at 4:25 PM, with LVN 1, LVN 1 stated he was unable to administer Resident 95, 64, and 24's medications on time because he was very new to the facility. LVN 1 stated the delay was also caused by facility staff interrupting and asking him questions during medication administration. LVN 1 stated he misunderstood the facility's policy for medication administration and stated medications were allowed to be given as early as 1 hour before and 1 hour after the scheduled medication time. LVN 1 stated LVN 1 stated a lapse in the medication administration time decreases the level of medication in the residents' system which could cause the residents to display side effects like hyperglycemia, hypertension or increased symptoms of depression. LVN 1 stated it was important to give the residents medications on time to receive the optimum effect of the medications. 4. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that affects one or both lungs), chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and emphysema (a long term lung condition that causes shortness of breath). During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 82 required setup or clean-up assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 82 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, sit to lying, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 82's Order Summary Report, dated 1/29/2026, the Order Summary Report indicated a physician order, with a start date of 1/21/2026 for prednisone 10 mg, give 1 tablet by mouth one time a day for COPD. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 82's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 82 was scheduled to receive Prednisone 10 mg at 7:15 AM. During an interview on 1/29/2026, at 10:03 AM, LVN 2 stated she did not administer Resident 52's prednisone 10 mg tablet at 7:15 AM because Resident 52 was asleep. LVN 2 stated she had until 8:15 AM to administer Resident 52's prednisone. LVN 2 stated she did not return to Resident 52's room before 8:15 AM because she was busy giving medications to another resident. LVN 2 stated it was important to administer Resident 52's prednisone on time since it had to be administered with food and needed time to be absorbed in the body. LVN 2 stated prednisone was a steroid and was ordered to prevent Resident 52's COPD exacerbation. LVN 2 stated medications should also be administered on time to prevent interacting with other medications. During an interview on 1/28/2026, at 9:22 AM, with the Director of Nursing (DON), the DON stated facility staff were allowed to administer the residents' medications one (1) hour before and 1 hour after the scheduled administration time. The DON stated the latest time a medication scheduled for 7:15 AM could be administered was 8:15 AM. The DON also stated the latest time a 9 AM medication could be administered was 10 AM. During a follow up interview on 1/29/2026, at 2:21 PM, with the DON, the DON stated administering the residents' medications on time was part of being compliant with the resident care. The DON stated it was important for medications to be given as ordered for medications to work and be effective. The DON stated diabetes and blood pressure medications were important medications that should be given as on time because the residents could experience symptoms of hyperglycemia or hypertension if not given as scheduled. The DON stated LVN 2 should have returned to resident 52's room before 8:15 AM to check if he was already awake. The DON also stated licensed nurses assigned to medication administration should focus on medication administration and tell staff not to interrupt them during medication administration unless it is an emergency. The DON stated LVN 1 and LVN 2 did not follow the facility's policy to administer medications on time. During a review of the facility's P&P, titled, Administering Medications, revised 4/2019, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are not administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour or their prescribed time, unless otherwise specified. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed Resident to administer the medication. 5. During a review of Resident 15's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of injury of the right hip, varicose veins (swollen, twisted, blue or dark purple veins that bulge just under the skin, most commonly appearing in the legs, ankles, and feet (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	includes aching), cellulitis (a common, potentially serious bacterial skin infection affecting the skin's deeper layers and underlying tissue, often causing rapid-spreading redness, pain, swelling, and warmth) of right lower limb, and spinal stenosis (the narrowing of spaces within the spine, putting pressure on nerves and the spinal cord, causing pain, numbness, or weakness in the neck, back, arms, or legs). During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident was independent in cognitive (the ability to think and understand) skills for daily decision making. The MDS also indicated Resident 15 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. Resident 15 required substantial/ maximal assistance with upper body dressing. The MDS indicated Resident 15 had frequent severe pain in the last five (5) days that has frequently affected the resident's day-to-day activities. During a review of Resident 15's Physician Orders, dated 1/15/2026, the Physician Orders indicated Tramadol Hydrochloride (HCL) (opioid [commonly used for pain relief but can also cause drowsiness and addiction]) 50 mg by mouth every 6 hours as needed for severe pain (7/10 to 10/10 in the 0-10 pain scale, 0 being no pain and 10 being the worst pain). Hold if drowsy/sleepy or respiratory rate is less than 12. During a review of Resident 15's MAR, dated 1/2026, the MAR indicated Tramadol HCL oral tablet 50 mg was administered on 1/29/2026 at 8:16AM. During a concurrent observation, review, and interview with LVN 2 on 1/29/2026 at 11:40 AM, Resident 15's Tramadol HCL bubble packet was observed with 15 tablets which did not match the narcotic sheet which indicated 16 tablets were available. LVN 2 stated Resident 15's narcotic sheet was not and should have been signed on 1/29/2026 to prevent over- or underdosing the resident with pain medication and to prevent missing/ possible misuse of medications. During a concurrent observation and interview on 1/29/2026 at 12:30PM, Resident 15 was lying in bed watching television. Resident 15 stated she received her pain medication around 8am that morning but was not able to specify the name of the medication. 6. During a review of Resident 109's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following but not limited to diagnoses of fracture (broken bone) of the left humerus (he bone of the upper arm, forming joints at the shoulder and the elbow) and left femur (the bone of the thigh), and spinal stenosis. During a review of Resident 109's History and Physical (H&P), dated 1/26/2026, the H&P indicated the resident has a pain of 5/10 due to fracture. The H&P also indicated that the resident has chronic back pain. During a review of Resident 109's Physician Order, dated 1/25/2026, the Physician Order indicated Oxycodone HCL (a potent, semi-synthetic opioid medication used to manage moderate-to-severe pain) oral tablet 5 mg. Give 1 tablet by mouth every 4 hours as needed for severe pain. Hold if drowsy/sleepy or respiratory rate less than 12. During a review of Resident 109's MAR, dated 1/2026, the MAR indicated Oxycodone HCL 5 mg was (continued on next page)		

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Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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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	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered on 1/29/2026 at 8:31AM. During a concurrent observation, review, and interview with LVN 2 on 1/29/2026 at 11:40 AM, Resident 109's Oxycodone HCl bubble packet was observed with 26 tablets which did not match the narcotic sheet which indicated 27 tablets were available. LVN 2 stated she administered Oxycodone HCl medication to Resident 109 but did not document it in the narcotic sheet. LVN 2 also stated she should have signed the narcotic sheet after administering Oxycodone HCl to Resident 109 to prevent over- or underdosing the resident with pain medication and to prevent missing/ possible misuse of medications. During a concurrent observation and interview on 1/29/2026 at 12:45 PM, Resident 109 was lying in bed watching television. Resident 15 stated she received her pain medication around 8am that morning but was not able to specify the name of the medication. During an interview with the DON on 1/29/2026 at 2:49 PM, the P&P titled, Controlled Substances, revised 4/2019, was reviewed. The DON stated the staff need to sign the narcotic sheet to prevent missing/misused of opioids and over or underdosing the resident. During a review of the facility's P&P titled, Controlled Substances, revised 4/2019, the P&P indicated the nurse administering the medication is responsible for recording the following in the narcotic sheet: Name of the resident receiving the medication Name, strength and dose of the medication Time of administration Method of administration Quantity of the medication remaining, and Signature of nurse administering medication.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Eight (8) medication errors (the observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order/manufacture's specifications/accepted professional standards and principles) out of 29 opportunities (observed administered medications) for error which yielded a facility medication error rate of 27.59% for four (4) of 10 sampled residents (Residents 95, 64, 24, and 82) observed for medication administration (med pass). Licensed Vocational Nurse 1 (LVN 1) failed to administer metformin (medication used to control high blood sugar levels) and potassium chloride (medication used to regulate the heartbeat) within 60 minutes of the scheduled time of 7:15 AM for Resident 95. LVN 1 failed to administer metoprolol tartrate (a medication used to treat high blood pressure) within 60 minutes of scheduled time of 7:15 AM for Resident 64. LVN 1 failed to administer Aspirin (a medication used as prophylaxis [action to prevent disease] for cerebrovascular accident [CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]), docusate sodium (a medication used to soften the stool), venlafaxine (Effexor- a medication used to treat major depressive disorder), memantine (Namenda- a medication used to treat moderate to severe dementia), and Vitamin D3 (a supplement for immune, muscle, and bone health) within 60 minutes of scheduled time of 9 AM for Resident 24. LVN 2 failed to administer prednisone (medication used to suppress the body's immune response and inflammation in the lungs) within 60 minutes of scheduled time of 7:15 AM for Resident 82. These deficient practices had the potential to result in harm to Residents 95, 64, 24, and 82 by not administering medications as prescribed by the physician in order to meet their individual medication needs. Findings: 1. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that begins and ends suddenly with episodes lasting not more than seven days), nonrheumatic mitral valve insufficiency (a leaky heart valve on the left side that does not close properly, allowing blood to flow backward into the heart), and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 95's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 95 was assessed having moderately impaired memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 95 required setup or clean-up assistance with eating, upper body dressing, and rolling left and right. The MDS indicated Resident 95 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, and putting on/taking off footwear. During a review of Resident 95's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications: Metformin HCl 1000 milligrams (mg-unit of measurement), give 1 tablet by mouth one time a day for DM, ordered on 10/8/2025. Potassium chloride 20 milliequivalent (mEq- unit of measurement), give 1 tablet by mouth one time a day for hypokalemia, ordered on 7/30/2025. During a review of Resident 95's Medication Administration Record (MAR), from 1/1/2026 to 1/31/2026, the MAR indicated Resident 95 was scheduled to receive the following medications at 7:15 AM: Metformin HCl 1000 mg Potassium chloride 20 mEq. During an observation of the medication pass on 1/28/2026, at 8:55 AM, Licensed Vocational Nurse 1 (LVN 1) administered the following medications to Resident 95: Metformin HCl 1000 mg, 1 tablet by mouth Potassium chloride 20 mEq, 1 tablet by mouth. 2. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential hypertension (HTN- high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles in the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood), and depression (a treatable mood disorder characterized by persistent sadness, loss of interest in activities and feelings of hopelessness).During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 64 required partial/moderate assistance upper body dressing, sit to stand, toilet transfer, and tub/shower transfer. The MDS indicated Resident 64 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear.During a review of Resident 64's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order, ordered on 9/5/2025, for metoprolol tartrate, give 12.5 (1/2 tab of 25 mg tablet) mg by mouth two times a day for HTN, hold for systolic blood pressure (SBP- pressure in the arteries when the heart contracts and pumps blood out) less than 110 or heart rate (HR) less than 60.During a review of Resident 64's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 64 was scheduled to receive metoprolol tartrate 12.5 mg at 7:15 AM.During an observation of the medication pass on 1/28/2026, at 9:12 AM, LVN 1 administered metoprolol tartrate 12.5 mg, 1/2 tablet by mouth to Resident 64.During an interview on 1/28/2026, at 9:13 AM, with LVN 1, LVN 1 stated Resident 64's metoprolol was scheduled to be given at 7:15 AM. LVN 1 stated the facility staff were allowed to administer medications two (2) hours before and 2 hours after the scheduled medication time.3.During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (a brain disorder that results in memory loss, poor judgment, and confusion), major depressive disorder (depression), and essential hypertension.During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 24 required supervision or touching assistance with eating, oral/toileting/personal hygiene, upper body dressing, and sit to lying. The MDS indicated Resident 24 required substantial/maximal assistance with shower/bathe self, lower body dressing, putting on/taking off footwear, sit to stand, and toilet transfer.During a review of Resident 24's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications:Aspirin tablet chewable 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients) prophylaxis (action to prevent disease), ordered on 9/26/2025.Docusate sodium 100 mg, give 200 mg (2 tabs) by mouth one time a day for bowel management, hold for loose stools, ordered on 6/12/2025.Effexor XR oral capsule extended release 24-hour 75 mg (venlafaxine HCl), give 1 capsule by mouth one time a day for major depressive disorder, ordered on 9/26/2025.Namenda tablet 5 mg (memantine HCl), give 1 tablet by mouth two times a day for dementia, ordered on 6/22/2021.Vitamin D3 (cholecalciferol) 1000 IU, give 2000 IU (2 tabs) by mouth one time a day for Vitamin D deficiency, ordered on 9/26/2025.During a review of Resident 24's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 24 was scheduled to receive the following medications at 9 AM:Aspirin tablet chewable 81 mgDocusate sodium 200 mg.Effexor XR oral capsule extended release 75 mgNamenda tablet (memantine HCl) 5 mgVitamin D3 (cholecalciferol) 2000 IUDuring an observation of the medication pass on 1/28/2026, at 10:24 AM, LVN 1 administered the following medications to Resident 24:Aspirin tablet chewable 81 mg, 1 tablet by mouthDocusate sodium 100 mg, 2 tablets by mouthEffexor XR 75 mg (venlafaxine HCl), 1 capsule by mouthNamenda tablet 5 mg (memantine HCl), 1 tablet by mouthVitamin D3 (cholecalciferol) 1000 IU, 2 tabs by mouthDuring a concurrent interview and record review on 1/28/2026, at 4:15 PM, with LVN 1, Residents 95, 64, and 24's MARs were reviewed. LVN 1 stated the following medications were not administered within 60 minutes of their scheduled time:Residents 95's potassium chloride, and metformin medications.Resident 64's metoprolol medication. Resident 24's Aspirin, docusate sodium, venlafaxine, memantine, and vitamin D3 medications. During a follow up interview on 1/28/2026, at 4:25 PM, with LVN 1, LVN 1 stated he was unable to administer (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 95, 64, and 24's medications on time because he was very new to the facility. LVN 1 stated the delay was also caused by facility staff interrupting and asking him questions during medication administration. LVN 1 stated he misunderstood the facility's policy for medication administration and stated medications were allowed to be given as early as 1 hour before and 1 hour after the scheduled medication time. LVN 1 stated LVN 1 stated a lapse in the medication administration time decreases the level of medication in the residents' system which could cause the residents to display side effects like hyperglycemia, hypertension or increased symptoms of depression. LVN 1 stated it was important to give the residents medications on time to receive the optimum effect of the medications.4.During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that affects one or both lungs), chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and emphysema (a long term lung condition that causes shortness of breath).During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 82 required setup or clean-up assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 82 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, sit to lying, sit to stand, and chair/bed-to-chair transfer.During a review of Resident 82's Order Summary Report, dated 1/29/2026, the Order Summary Report indicated a physician order, with a start date of 1/21/2026 for prednisone 10 mg, give 1 tablet by mouth one time a day for COPD.During a review of Resident 82's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 82 was scheduled to receive Prednisone 10 mg at 7:15 AM.During an interview on 1/29/2026, at 10:03 AM, LVN 2 stated she did not administer Resident 52's prednisone 10 mg tablet at 7:15 AM because Resident 52 was asleep. LVN 2 stated she had until 8:15 AM to administer Resident 52's prednisone. LVN 2 stated she did not return to Resident 52's room before 8:15 AM because she was busy giving medications to another resident. LVN 2 stated it was important to administer Resident 52's prednisone on time since it had to be administered with food and needed time to be absorbed in the body. LVN 2 stated prednisone was a steroid and was ordered to prevent Resident 52's COPD exacerbation. LVN 2 stated medications should also be administered on time to prevent interacting with other medications.During an interview on 1/28/2026, at 9:22 AM, with the Director of Nursing (DON), the DON stated facility staff were allowed to administer the residents' medications one (1) hour before and 1 hour after the scheduled administration time. The DON stated the latest time a medication scheduled for 7:15 AM could be administered was 8:15 AM. The DON also stated the latest time a 9 AM medication could be administered was 10 AM.During a follow up interview on 1/29/2026, at 2:21 PM, with the DON, the DON stated administering the residents' medications on time was part of being compliant with the resident care. The DON stated it was important for medications to be given as ordered for medications to work and be effective. The DON stated diabetes and blood pressure medications were important medications that should be given as on time because the residents could experience symptoms of hyperglycemia or hypertension if not given as scheduled. The DON stated LVN 2 should have returned to resident 52's room before 8:15 AM to check if he was already awake. The DON also stated licensed nurses assigned to medication administration should focus on medication administration and tell staff not to interrupt them during medication administration unless it is an emergency. The DON stated LVN 1 and LVN 2 did not follow the facility's policy to administer medications on time.During a review of the facility's P&P, titled, Administering Medications, revised 4/2019, the P&P indicated the following:Medications are administered in a safe and timely manner, and as prescribed.Staffing schedules are arranged to ensure that medications are not administered without unnecessary interruptions.Medications are administered in accordance with prescriber orders, including any required time frame.Medications are administered within one hour or their prescribed time, unless otherwise specified.For residents not in (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed Resident to administer the medication.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four (4) of 10 sampled residents (Resident 95, 64, 24, and 82) were free from significant medication errors by facility to: 1. Administer metformin (medication used to control high blood sugar levels) and potassium chloride (medication used to regulate the heartbeat) within 60 minutes of the scheduled time of 7:15 AM for Resident 95. This deficient practice had the potential for Resident 95 to experience chest pain, shortness of breath, dizziness, and placed Resident 95 at risk for inadequate blood sugar management which could cause hyperglycemia (elevated blood sugar level). 2. Administer metoprolol tartrate (a medication used to treat high blood pressure) within 60 minutes of scheduled time of 7:15 AM for Resident 64. This deficient practice had the potential for Resident 64 to experience high blood pressure and a decline in overall health status. 3. Administer Aspirin (a medication used as prophylaxis [action to prevent disease] for cerebrovascular accident [CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients]), docusate sodium (a medication used to soften the stool), venlafaxine (Effexor- a medication used to treat major depressive disorder), memantine (Namenda- a medication used to treat moderate to severe dementia), and Vitamin D3 (a supplement for immune, muscle, and bone health) within 60 minutes of scheduled time of 9 AM for Resident 24. This deficient practice had the potential for a decline in Resident 24's overall health status and decrease the therapeutic levels of Resident 24's memantine and namenda which could cause Resident 24's dementia and depression symptoms to worsen or not be properly managed. 4. Administer prednisone (medication used to suppress the body's immune response and inflammation in the lungs) within 60 minutes of scheduled time of 7:15 AM for Resident 82. This deficient practice had the potential for Resident 82 to experience shortness of breath and chronic obstructive pulmonary disease (COPD- a long term lung disease causing difficulty breathing) exacerbation (a sudden, significant worsening of a pre-existing disease where symptoms become more severe and may require a change in treatment or emergency care). Findings: 1. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that begins and ends suddenly with episodes lasting not more than seven days), nonrheumatic mitral valve insufficiency (a leaky heart valve on the left side that does not close properly, allowing blood to flow backward into the heart), and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 95's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 95 was assessed having moderately impaired memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 95 required setup or clean-up assistance with eating, upper body dressing, and rolling left and right. The MDS indicated Resident 95 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, and putting on/taking off footwear. During a review of Resident 95's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications: Metformin HCl 1000 milligrams (mg-unit of measurement), give 1 tablet by mouth one time a day for DM, ordered on 10/8/2025. Potassium chloride 20 milliequivalent (mEq- unit of measurement), give 1 tablet by mouth one time a day for hypokalemia, ordered on 7/30/2025. During a review of Resident 95's Medication Administration Record (MAR), from 1/1/2026 to 1/31/2026, the MAR indicated Resident 95 was scheduled to receive the following medications at 7:15 AM: Metformin HCl 1000 mg Potassium chloride 20 mEq During an observation of the medication pass on 1/28/2026, at 8:55 AM, Licensed Vocational Nurse 1 (LVN 1) administered the following medications to Resident 95: Metformin HCl 1000 mg, 1 tablet by mouth Potassium chloride 20 mEq, 1 tablet by mouth 2. During a review of Resident 64's (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission Record, the admission Record indicated Resident 64 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential hypertension (HTN- high blood pressure), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and depression (a treatable mood disorder characterized by persistent sadness, loss of interest in activities and feelings of hopelessness). During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 64 required partial/moderate assistance upper body dressing, sit to stand, toilet transfer, and tub/shower transfer. The MDS indicated Resident 64 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 64's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order, ordered on 9/5/2025, for metoprolol tartrate, give 12.5 (1/2 tab of 25 mg tablet) mg by mouth two times a day for HTN, hold for systolic blood pressure (SBP- pressure in the arteries when the heart contracts and pumps blood out) less than 110 or heart rate (HR) less than 60. During a review of Resident 64's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 64 was scheduled to receive metoprolol tartrate 12.5 mg at 7:15 AM. During an observation of the medication pass on 1/28/2026, at 9:12 AM, LVN 1 administered metoprolol tartrate 12.5 mg, 1/2 tablet by mouth to Resident 64. During an interview on 1/28/2026, at 9:13 AM, with LVN 1, LVN 1 stated Resident 64's metoprolol was scheduled to be given at 7:15 AM. LVN 1 stated the facility staff were allowed to administer medications two (2) hours before and 2 hours after the scheduled medication time. 3. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (a brain disorder that results in memory loss, poor judgment, and confusion), major depressive disorder (depression), and essential hypertension. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 24 required supervision or touching assistance with eating, oral/toileting/personal hygiene, upper body dressing, and sit to lying. The MDS indicated Resident 24 required substantial/maximal assistance with shower/bathe self, lower body dressing, putting on/taking off footwear, sit to stand, and toilet transfer. During a review of Resident 24's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for the following medications: Aspirin tablet chewable 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA- a medical emergency where blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients) prophylaxis (action to prevent disease), ordered on 9/26/2025. Docusate sodium 100 mg, give 200 mg (2 tabs) by mouth one time a day for bowel management, hold for loose stools, ordered on 6/12/2025. Effexor XR oral capsule extended release 24 hour 75 mg (venlafaxine HCl), give 1 capsule by mouth one time a day for major depressive disorder, ordered on 9/26/2025. Namenda tablet 5 mg (memantine HCl), give 1 tablet by mouth two times a day for dementia, ordered on 6/22/2021. Vitamin D3 (cholecalciferol) 1000 IU, give 2000 IU (2 tabs) by mouth one time a day for Vitamin D deficiency, ordered on 9/26/2025. During a review of Resident 24's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 24 was scheduled to receive the following medications at 9 AM: Aspirin tablet chewable 81 mg Docusate sodium 200 mg. Effexor XR oral capsule extended release 75 mg Namenda tablet (memantine HCl) 5 mg Vitamin D3 (cholecalciferol) 2000 IU During an observation of the medication pass on 1/28/2026, at 10:24 AM, LVN 1 administered the following medications to Resident 24: Aspirin tablet chewable 81 mg, 1 tablet by mouth Docusate sodium 100 mg, 2 tablets by mouth Effexor XR 75 mg (venlafaxine HCl), 1 capsule by mouth Namenda tablet 5 mg (memantine HCl), 1 tablet by mouth Vitamin D3 (cholecalciferol) 1000 IU, 2 tabs by mouth During a concurrent interview and record review on 1/28/2026, at 4:15 PM, with LVN 1, Residents 95, 64, and 24's MARs were reviewed. LVN 1 stated the following medications were not administered within 60 minutes of their scheduled time: Residents (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	95's potassium chloride, and metformin medications. Resident 64's metoprolol medication. Resident 24's Aspirin, docusate sodium, venlafaxine, memantine, and vitamin D3 medications. During a follow up interview on 1/28/2026, at 4:25 PM, with LVN 1, LVN 1 stated he was unable to administer Resident 95, 64, and 24's medications on time because he was very new to the facility. LVN 1 stated the delay was also caused by facility staff interrupting and asking him questions during medication administration. LVN 1 stated he misunderstood the facility's policy for medication administration and stated medications were allowed to be given as early as 1 hour before and 1 hour after the scheduled medication time. LVN 1 stated LVN 1 stated a lapse in the medication administration time decreases the level of medication in the residents' system which could cause the residents to display side effects like hyperglycemia, hypertension or increased symptoms of depression. LVN 1 stated it was important to give the residents medications on time to receive the optimum effect of the medications. 4. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that affects one or both lungs), chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and emphysema (a long term lung condition that causes shortness of breath). During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 82 required setup or clean-up assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 82 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, sit to lying, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 82's Order Summary Report, dated 1/29/2026, the Order Summary Report indicated a physician order, with a start date of 1/21/2026 for prednisone 10 mg, give 1 tablet by mouth one time a day for COPD. During a review of Resident 82's MAR, from 1/1/2026 to 1/31/2026, the MAR indicated Resident 82 was scheduled to receive Prednisone 10 mg at 7:15 AM. During an interview on 1/29/2026, at 10:03 AM, LVN 2 stated she did not administer Resident 52's prednisone 10 mg tablet at 7:15 AM because Resident 52 was asleep. LVN 2 stated she had until 8:15 AM to administer Resident 52's prednisone. LVN 2 stated she did not return to Resident 52's room before 8:15 AM because she was busy giving medications to another resident. LVN 2 stated it was important to administer Resident 52's prednisone on time since it had to be administered with food and needed time to be absorbed in the body. LVN 2 stated prednisone was a steroid and was ordered to prevent Resident 52's COPD exacerbation. LVN 2 stated medications should also be administered on time to prevent interacting with other medications. During an interview on 1/28/2026, at 9:22 AM, with the Director of Nursing (DON), the DON stated facility staff were allowed to administer the residents' medications one (1) hour before and 1 hour after the scheduled administration time. The DON stated the latest time a medication scheduled for 7:15 AM could be administered was 8:15 AM. The DON also stated the latest time a 9 AM medication could be administered was 10 AM. During a follow up interview on 1/29/2026, at 2:21 PM, with the DON, the DON stated administering the residents' medications on time was part of being compliant with the resident care. The DON stated it was important for medications to be given as ordered for medications to work and be effective. The DON stated diabetes and blood pressure medications were important medications that should be given as on time because the residents could experience symptoms of hyperglycemia or hypertension if not given as scheduled. The DON stated LVN 2 should have returned to resident 52's room before 8:15 AM to check if he was already awake. The DON also stated licensed nurses assigned to medication administration should focus on medication administration and tell staff not to interrupt them during medication administration unless it is an emergency. The DON stated LVN 1 and LVN 2 did not follow the facility's policy to administer medications on time. During a review of the facility's P&P, titled, Administering Medications, revised 4/2019, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are not administered (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour or their prescribed time, unless otherwise specified. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed Resident to administer the medication.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to provide safe and sanitary storage and handling of food brought in by resident's family or other visitors in accordance with the facility's policy and procedure (P&P) titled Food Brought in by Family/Visitors when: 1. Three (3) unopened Ensure drinks (nutrient-dense, ready-to-drink meal replacements designed to provide protein, vitamins, minerals, and calories for individuals needing extra nutrition) were not labeled with the resident's name 2. One (1) opened apple juice bottle was not labeled with use-by date (the date up until which a food may be used safely).3. Staff food item and an unlabeled container with food (unknown if for resident or staff) were stored in the designated refrigerator for residents' use.During a concurrent observation and interview on 1/28/2026 at 10:55 AM with the Activity Director (AD) and Licensed Vocational Nurse 4 (LVN 4) in the Activity Room, the refrigerator designated for residents' use was observed. AD and LVN 4 confirmed three (3) unopened Ensure drinks were stored in the refrigerator without a label indicating resident's name and one (1) opened apple juice bottle was not labeled with use-by date. In addition, AD and LVN verified that there was one (1) fruit plate dated 1/28 belonged to a staff and one (1) unlabeled container with food were in the refrigerator. AD and LVN 4 stated food items for residents should be labeled with resident's name, room number and use by date. The AD and LVN 4 stated staff's food and the unlabeled container with food should not be stored in the refrigerator designated for residents' use. During an interview on 1/28/2026 at 3:37 PM with the Activity Staff 1 (AA 1), AA 1 stated she put her food in the residents' refrigerator. AA 1 stated she was aware that the refrigerator was only for residents' use but still stored her food there. AA 1 stated there was a potential risk for cross contamination (microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) if staff food and residents' food items were stored in the same refrigerator. During a concurrent interview and record review on 1/28/2026 at 3:50 PM with the Administrator (ADM), the facility's P&P titled Food brought in by Family/Visitors revised on 10/2017 was reviewed. The P&P indicated food brought in by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility prepared food and containers will be labeled with the resident's name, the item and the use by date. ADM stated this P&P is applicable to the food stored in the resident's refrigerator located in the activity room. ADM stated food brought in by family or visitors for the residents including bottled juice or protein supplement drinks such as Ensure are stored in the refrigerator for residents' use only. ADM stated the residents' food items should be labeled with resident's name, room number, and use-by date if opened. During the same interview on 1/28/2026 at 3:50 PM with the ADM, ADM stated food belonging to staff should not be stored in the residents' refrigerator. ADM stated placing food items belonging to staff or unlabeled with the resident's name may pose a risk of cross contamination. ADM stated unlabeled food items may be mistakenly given to residents that may cause illness or food not according to the resident's diet order may be served to the residents. ADM stated that no food/food items belonging to staff stored in the residents' refrigerator should be included in the facility's P&P. During a review of the facility's undated P&P titled Bringing in Food for a Resident, the P&P indicated food, or beverages should be labeled and dated to monitor for food safety. The P&P also indicated, food or beverages in the original containers marked with manufacturer expiration dates and unopened, need to be marked with resident's name.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to observe infection control measures for four of 19 sampled residents (Residents 5, 49, 105, 9 and 95) as indicated on the facility policy by failing to ensure: Treatment Nurse 1 (TN 1) performed hand hygiene (washing hands with soap and water for at least 20 seconds, or using alcohol-based sanitizer, to effectively eliminate germs and prevent disease spread) after removing a soiled wound dressing for Resident 5. TN 1 performed hand hygiene after touching a bedside table in Resident 49's room (Room B -room that is on enhanced barrier precaution room [EBP- infection control measures that require healthcare workers to wear gowns and gloves during all high-contact resident care activities to prevent the spread of multi-drug resistant organisms {MDROs}]), and before preparing treatment for Resident 105, who is in Room A (on enhanced barrier precaution room). Laundry Staff (LS) performed hand hygiene after picking up trash from the floor, opening the trash can lid to throw the trash in, and before touching the clean linen. Staff performed hand hygiene when providing wound treatment between two different wound sites of Resident 9. Blood sugar glucose monitor (a medical device used to measure the concentration of glucose in the blood) was cleaned before and after checking Resident 95's blood sugar. These failures had the potential to result in an increased risk for the spread of bacteria, viruses and pathogens (harmful microorganisms) to the residents, visitors and staff throughout the facility. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on left upper back, immunodeficiency (a failure of the immune system to protect the body adequately from infection) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 1/6/2026, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 5 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) with toileting hygiene, lower body dressing and putting on/taking off footwear but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 5 has one unhealed pressure ulcer stage 2 (location not indicated). During an interview on 1/26/2026 at 8:59 AM in Resident 5's room, Resident 5 stated she has a wound on her butt. During a wound care observation on 1/28/2026 at 9:32 AM, TN 1 was observed taking off Resident 5's soiled dressing and changing gloves without performing hand hygiene. TN 1 then continued with providing wound care to Resident 5. During an interview on 1/28/2026 at 12:25 PM, TN 1 stated he should have performed hand hygiene after taking off the dirty/ soiled wound dressing and before putting on a new gloves to prevent transmission (the act of transferring something from one spot to another) of microorganisms (a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bacterium, virus, or fungus). During an interview on 1/28/2026 at 12:41 PM, the Director of Nursing (DON) stated gloves do not replace hand hygiene and if TN 1 removed a dirty/ soiled wound dressing, then TN 1 should perform hand hygiene and changed gloves before proceeding to prevent the spread of infection. During an interview on 1/29/2025 at 10:39 AM, Infection Preventionist Nurse (IPN) stated TN 1 should have performed hand hygiene before putting on a clean set of gloves because the soiled wound dressing is dirty and can have bacteria on it which can be transmitted. During an interview on 1/29/2026 at 2:58 PM, the facility's Policy and Procedure (P&P) titled Handwashing/ Hand hygiene, revised 8/2019, was reviewed. The P&P indicated the P&P indicated to use alcohol-based hand rub or wash with soap and water after handling used dressings. The DON stated gloves should only be used once and should be discarded after removal of soiled dressing, perform hand hygiene and put on a new set of gloves before moving on to the next tasks/ clean task. During a review of the facility's P&P titled Personal Protective Equipment, revised 7/2009, the P&P indicated gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. The P&P also indicated to wash hands after removing gloves. 2. During a review of Resident 49's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with the following but not limited to diagnoses of chronic ulcer (a small open sore or wound generally found in the stomach or on the skin) of the right and left foot, amputation (surgical removal of a portion of the body) of two or more of left toes, and DM. During a review of Resident 49's MDS, dated [DATE], the MDS indicated the resident was independent in cognitive skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance with toileting hygiene, lower body dressing and putting on/taking off footwear but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with shower/bathe self. During a review of Resident 105's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of cellulitis (a skin infection that causes swelling and redness) of the left and right lower limb and ulcer of left lower leg. During a review of Resident 105's History and Physical (H&P), dated 1/28/2025, the H&P indicated the resident has decision making capacities. During a review of the facility's Infection Control Map, dated 01/2026, the map indicated Resident 49's room (Room B) and 109's room (Room A) are considered rooms with residents that have a community acquired skin infection and is on EBP. During an observation in Room B on 1/28/2026 at 10:17 AM, TN 1 was observed going into Room B and touching Resident 49's bedside table. TN 1 left the room and was observed taking equipment from the treatment cart and preparing treatment for Resident 105 (in Room A) without performing hand (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene. During an interview on 1/28/2026 at 10:50 AM, TN 1 stated he did not perform hand hygiene after coming out of Room B and prior to preparing Resident 105's treatment. TN 1 also stated he should have performed hand hygiene after touching Resident 40's bedside table/ before coming out of Room B and before touching the treatment cart to prepare the treatment for Resident 105 to prevent the spread of infection. During an interview on 1/28/2026 at 11:15 AM, the DON stated TN 1 is supposed to perform hand hygiene before entering the resident's room and after exiting the resident's room especially after contact with the residents' immediate vicinity. The DON also stated hand hygiene needs to be performed before preparing for the treatment to prevent the spread of infection. During an interview on 1/29/2026 at 2:58 PM, the facility's P&P titled Handwashing/ Hand hygiene, revised 8/2019, was reviewed. The DON stated TN 1 should perform hand hygiene before handling the clean dressings/ supplies in the treatment cart. During a review of the facility's P&P titled Handwashing/ Hand hygiene, revised 8/2019, the P&P indicated to use alcohol based hand rub (ABHR -the preferred, fast-acting method for reducing germs on hands when they are not visibly soiled) or wash with soap and water after contact with objects in the immediate vicinity of the resident and before handling clean dressing, gauze pads, etc. 3. During a concurrent observation in the facility's laundry room and interview on 1/29/2026 at 9:45 AM with IPN present, the Laundry Staff (LS) was observed picking up trash from the floor, opening the trash can lid to throw the trash away. LS was then observed taking clean linen out of the dryer and folding it without performing hand hygiene. IPN stated LS should have conducted hand hygiene prior to handling the clean linen to prevent the spread of infection. During an interview on 1/29/2026 at 2:43 PM, the DON stated LS should have performed hand hygiene after handling the trash and before continuing with the clean laundry because it can spread infection and contaminate the clean linen. During an interview on 1/29/2026 at 3:30 PM, the facility's P&P titled, Laundry Services, revised 5/15/2011, was reviewed. The DON stated the P&P indicated the laundry should be kept clean to prevent spread of infection. 4. During a review of Resident 9's admission Record, the admission record indicated Resident 9 was admitted to the facility on [DATE], with the diagnoses including but not limited to pressure ulcer of sacral (bone at the end of the spine) region stage 3 (full thickness tissue loss, subcutaneous [under the skin] fat may be visible but bone, tendon or muscle are not exposed), extended spectrum beta-lactamase (ESBL, a group of bacteria that cause infections in healthcare settings and communities that resist effects of common antibiotics) resistance, and metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function). During a record review of Resident 9's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making is severely impaired. The MDS indicated Resident 9 was dependent for toileting hygiene, shower/bathing self, and personal hygiene. The MDS also indicated Resident 9 was at risk of pressure ulcers/injuries and had an unhealed pressure ulcer/injury. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 9's Order Summary Report, indicated as follows: On 1/8/2026 Treatment: Reopened scar tissue on lower mid abdomen (Wound 2) &ndash; cleanse with normal saline (NS, mixture of salt and water used to replenish fluid and electrolyte), pat dry, collagen powder (used in wound treatment to stimulate new tissue growth) cover with border gauze dressing every day shift for 30 days. On 1/22/2026 Treatment: sacral area (Wound 1) &ndash; apply zinc oxide (a mineral compound used in wound care for its protective, antimicrobial, and supporting tissue repair properties) ointment for skin maintenance every shift for 30 days. During a record review of Resident 9's Care Plan, dated 1/6/2026, the Care Plan indicated Resident 9 had impaired skin integrity and was at risk for further complications related to site sacrum moisture associated skin damage (MASD, caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus). The Care Plan also indicated the nursing interventions for staff were to keep affected area clean and dry, provide good skin care every shift and as needed, and observe good handwashing. During a record review of Resident 9's Care Plan, dated 1/9/2026, the Care Plan indicated Resident 9 was at risk for infection and further complications related to site reopened scar tissue on lower mid abdomen. The Care Plan also indicated nursing interventions for staff were to provide treatment as ordered, observe and report signs of infection, and observe good hand washing. During an observation on 1/28/2026 at 9:05 AM in Resident 9's room with Treatment Nurse 1 (TN 1), TN 1 removed Resident 9's old wound dressing on Wound 2. TN 1 cleaned Wound 2 with NS, pat dry, applied collagen powder, and applied a bordered gauze dressing to Wound 2. TN 1 changed gloves without performing hand hygiene and proceeded to provide treatment to Wound 1. During an interview on 1/28/2026 at 9:19 AM with TN 1, TN 1 stated hand hygiene should be performed between wound sites when doing treatments to prevent the transmission of infection from one wound to another wound. TN 1 stated TN 1 did not perform hand hygiene after finishing treatment for Resident 9's Wound 2 and then proceeded to the resident's Wound 1. TN 1 stated he changed gloves after he finished the wound treatment for Resident 9's Wound 2 and started on Wound 1 and did not perform hand hygiene before putting on a new glove because changing his (TN 1's) gloves between the two wound sites was adequate and he did not need to perform hand hygiene. During a concurrent interview and record review on 1/29/2026 at 10:05 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Handwashing/Hand Hygiene, revised August 2019, the DON stated the P&P indicated the facility staff needed to change gloves and wash their hands then put another clean glove when moving from one wound to another wound to prevent or avoid contamination. The DON stated the facility's P&P indicated before moving from a contaminated body site staff must do proper hand hygiene. The DON also stated changing gloves between different wound treatments was not enough and staff needed to clean their hands by performing hand hygiene before putting on another clean glove. During a record review of the facility's P&P titled, Handwashing/Hand Hygiene, revised August 2019, the P&P indicated use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before moving from a contaminated body site to a clean body site during resident care. After contact with blood or bodily fluids. After handling used dressings, contaminated equipment, etc. 5. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that begins and ends suddenly with episodes lasting not more than seven days), nonrheumatic mitral valve insufficiency (a leaky heart valve on the left side that does not close properly, allowing blood to flow backward into the heart), and type 2 DM. During a review of Resident 95's MDS dated [DATE], the MDS indicated Resident 95 was assessed having moderately impaired memory and cognitive skills for daily decision making. The MDS indicated Resident 95 required setup or clean-up assistance with eating, upper body dressing, and rolling left and right. The MDS indicated Resident 95 required partial/moderate assistance with toileting hygiene, shower/bathe self, and putting on/taking off footwear. During a review of Resident 95's Order Summary Report, dated 1/28/2026, the Order Summary Report indicated a physician order for Accucheck (test for blood sugar) twice a day (bid) before (ac) breakfast and bedtime, every morning and at bedtime for type 2 DM, ordered on 10/8/2025. During an observation outside Resident 95's room, on 1/28/2026, at 8:46 AM, Licensed Vocational Nurse 1 (LVN 1) prepared the supplies needed to check Resident 95's blood sugar. LVN 1 removed the BGM, test strips, lancet (a small pen-like tool used to hold a tiny needle and quickly prick the skin to get a small drop of blood for BGM), and alcohol pads from the medication cart drawer and placed it in a clear plastic tray. LVN 1 entered Resident 95's room and checked Resident 95's blood sugar using the BGM and returned the BGM, used test strip, lancet and alcohol pad back in the clear plastic tray and exited the room. LVN 1 placed the clear plastic tray on top of the medication cart, doffed (remove) his (LVN 1) gloves, and performed hand hygiene. LVN 1 placed the BGM back inside the medication cart drawer. LVN 1 did not sanitize the BGM before and after using it to check Resident 95's blood sugar, and before putting the BGM back in the medication cart drawer. During an interview, on 1/28/2026, at 9:13 AM, with LVN 1, LVN 1 stated he did not sanitize the BGM before and after checking Resident 95's blood sugar. LVN 1 stated it was important to sanitize the BGM with the disinfecting wipe for infection control especially since it involved Resident 95's blood. LVN 1 stated not sanitizing the BGM could cause cross contamination between residents and transfer infection and illness from one resident to another and to staff. During an interview, on 1/29/2026, at 3:41 PM, with the Director of Nursing (DON), the DON stated licensed nurses were required to sanitize the BGM with a disinfecting wipe before and after resident use. The DON stated it was important to sanitize the BGM before and after use because checking Resident 95's blood sugar involved exposure to blood. The DON stated blood could carry blood borne pathogens (infectious microorganisms present in human blood that can cause serious or fatal diseases) which could transmit infection to other residents. The DON stated LVN 1 did not follow the policy for blood sugar monitoring and infection control. During a review of the facility's policy and procedure (P&P), titled, Blood Sampling-Capillary (Finger Sticks), revised 9/2014, the P&P indicated the following: (continued on next page)		

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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	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to resident and employees. Always ensure the blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. Replace blood glucose monitoring device in storage area after cleaning.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an antibiotic (type of medication that kills or inhibits the growth of bacteria) surveillance (the continuous tracking and analysis of how antibiotics are used and how bacteria are becoming resistant to them) data collection form was completed for two (2) of three (3) sampled residents (Resident 5 and 106) reviewed for antibiotic in accordance with the facility policy. This deficient practice had the potential for the residents to be prescribed inappropriate antibiotics and increased the risk for developing antibiotic-resistant organisms (bacteria that are not controlled or killed by antibiotics). Findings: 1. During a review of Resident 105's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of cellulitis (a skin infection that causes swelling and redness) of the left and right lower limb and ulcer (a small open sore or wound generally found in the stomach or on the skin) of left lower leg. During a review of Resident 105's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident has decision making capacities. During a review of Resident 105's Physicians Order, dated 1/28/2026, the Physicians order indicated meropenem (a potent, broad-spectrum intravenous carbapenem antibiotic used to treat severe bacterial infections) intravenous (administered into a vein or veins) Solution Reconstituted 2 gram (gm - unit of measure) Use 2 gram (gm- unit of measurement) intravenously every eight (8) hours for cellulitis of bilateral lower extremity until 2/6/2026. During an interview on 1/29/2026 at 9:23AM, the facility's Antibiotic Stewardship (the responsible and safe use of antibiotics to make sure they work when needed, now and in the future), dated 1/2026, was reviewed. Infection Preventionist Nurse (IPN) stated an antibiotic surveillance data collection form was not completed for Resident 105 receiving meropenem antibiotic. IPN also stated Resident 105 should have a surveillance data collection form completed for the use of meropenem to ensure the resident meets the criteria for the antibiotic use; and to ensure Resident 105 receives the correct antibiotic. The IPN stated completing an antibiotic surveillance form can help prevent the resident from developing multi-drug-resistant organisms (MDRO - are bacteria resistant to more than or equal to 3 classes of antibiotics). 2. During a review of Resident 106's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of cellulitis of the left lower limb, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and pressure ulcer stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound) on the sacral region (a shield-shaped, triangular bone at the base of the lumbar spine, connecting the vertebral column to the pelvis between the hip bones) and left heel. During a review of Resident 106's Minimum Data Set (MDS - a resident assessment tool), dated 1/25/2026, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) with eating, oral hygiene, and personal hygiene but was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, lower body dressing and putting on/taking off footwear. During a review of Resident 106's Physician Order, dated 1/22/2026, the Physician Order indicated Bactrim double strength (Bactrim DS- used to treat various bacterial infections, including urinary tract infections) oral tablet 800-160 milligrams (mg - unit of measure) give one (1) tablet by mouth two times a day for cellulitis for 10 days. During an interview on 1/29/2026 at 9:23AM, the facility's Antibiotic Stewardship, dated 01/2026 was reviewed. Infection Preventionist Nurse (IPN) stated an antibiotic surveillance data collection form was not completed for Resident 106 receiving Bactrim antibiotic. IPN also stated Resident 106 should have a surveillance data collection form completed for (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the use of Bactrim to ensure the resident meets the criteria for an antibiotic; and to ensure Resident 106 receives the correct antibiotic. The IPN stated completing a surveillance collection form can help prevent Resident 106 from developing MDRO. During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship - Orders for Antibiotics, revised 12/2016, the P&P indicated appropriate indications for use of antibiotics include criteria met for clinical definition of active infection or suspected sepsis (a life-threatening medical emergency caused by the body's overreaction to an infection, where the immune system attacks its own tissues and organs) and pathogen susceptibility (how easily a germ [bacteria or fungus] can be killed or stopped from growing by a specific antibiotic or medicine), based on culture and sensitivity (two-part laboratory procedure used to identify an infection and determine the best treatment), to antimicrobial. During a review of the facility's P&P titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised 12/2016, the P&P indicated antibiotic usage and outcome data will be collected and documented using the facility-approved antibiotic surveillance tracking form.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 8) reviewed for beneficiary notification was not provided with the Skilled Nursing Facility (SNF) Beneficiary Notification form (also called the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form, a Medicare [federal health insurance program] - required notice provided to Medicare beneficiaries when Medicare payment is expected to be denied for certain services or items) in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to result in Resident 8 not being able to exercise the resident's right to file an appeal and cause stress to the resident for inability to make adequate arrangements for charges that may be incurred. Findings: During a review of Resident 8's admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE], with the diagnoses including but not limited to schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), and cellulitis (an infection of the deeper layers of skin and the underlying tissue) of left lower limb. During a review of Resident 8's Minimum Data Set (MDS, a resident's assessment tool), dated 11/12/2025, the record indicated Resident 8's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower/bathing self, sitting to standing, and walking ten feet. During a review of Resident 8's Skilled Nursing Facility (SNF) Beneficiary Notification Review form completed on 1/28/2026, the form indicated Resident 8's Medicare Part A Skilled Services episode started on 9/30/2025 and the last day covered day of Part A Service ended on 12/3/2025. The form indicated SNF ABN Form was not provided to Resident 8. During an interview on 1/28/2026 at 3:15 PM with the Business Office Manager (BOM), BOM stated she did not know she needed to notify Resident 8 of the SNF ABN. BOM stated that it was important to inform and give the SNF ABN form to Resident 8 so the resident can understand and explain the benefits that the resident is covered and when will the coverage end. During a review of the facility's P&P titled, Advance Beneficiary Notice, revised 9/16/2024, the P&P indicated the facility designee will be responsible for completion of the ABN, as needed. The P&P also indicated upon notification of an item or service that may not be paid for by Medicare, the designated facility staff will: Prepare the notice for Part A, Part B or Exclusion. Review with the resident and/or authorized representative. Request Resident/authorized representative to indicate their preference on the notice, then sign/date. Provide resident/authorized representative with a copy of the notice. Provide business office with the original notice for filing in the business file and medical record. Retain the original notice on file.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to secure and provide confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) of medical records for one (1) of 1 sampled residents Resident 85) reviewed for privacy when Resident 85's wound treatment order was left exposed when Computer 1's (COM 1) screen was left open and unattended on 1/27/2026. This deficient practice violated Resident 85's right to privacy and confidentiality. Findings: During a review of Resident 85's admission Record, the admission Record indicated Resident 85 was admitted to the facility on [DATE] with diagnoses that included displaced supracondylar fracture with intracondylar extension of lower end of right femur (an injury where the thighbone breaks just about the knee joint), aftercare following joint replacement surgery (a procedure where a damaged or diseased joint is removed and replaced with an artificial implant), and difficulty in walking. During a review of Resident 85's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 85 was assessed having intact impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 85 required supervision or touching assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 85 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper/lower body dressing, rolling left and right, sit to stand, sit to lying, and walking 10 feet (ft- unit of measurement). During a review of Resident 85's physician order, dated 1/27/2026, the physician order indicated an order for treatment (tx) on skin discoloration on right lower extremity: monitor for skin integrity everyday shift for 14 days. During a concurrent observation in the Nurse's Station 1 (NS 1) and interview on 1/27/2026, at 9:29 AM, with the Administrator (ADM), COM 1 was observed unattended with Resident 85's wound treatment information on the computer screen. The ADM stated the computer screen should not have been left open/ unlocked and unattended. The ADM stated facility staff were supposed to lock the computer screen whenever they needed to walk away from the computer. During an interview, on 1/27/2026, at 3:52 PM, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated facility staff need to log off (ending the active user session and disconnecting from the computer while leaving the computer turned on) the computer before walking away to protect the residents' information. LVN 4 stated leaving the computer on and unattended, with Resident 85's wound treatment information exposed on the computer screen allows unauthorized staff and visitors to learn about Resident 85's wound. LVN 4 stated leaving the computer screen on and unattended was unacceptable in the facility. LVN 4 stated it was the residents' right to have their medical records kept confidential. During an interview, on 1/29/2026, at 3:30 PM, with the Director of Nursing (DON), the DON stated residents in the facility have a right to privacy. The DON stated staff, visitors, laboratory technicians and vendors could have accessed Resident 85's information when the computer screen was left on and unattended. The DON stated facility staff need to log off from the computer before stepping away because of the Health Insurance Portability and Accountability Act (HIPAA- a federal law that protects the privacy and security of a Resident's health information and sets rules for how it can be shared). The DON stated the facility's policy for privacy and confidentiality was not followed. During a review of the facility's policy and procedure, titled, Confidentiality of Information and Personal Privacy, revised 10/2017, the policy indicated the following: The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The facility will strive to protect the resident's privacy regarding his or her medical treatment. Access to Resident personal medical records will be limited to authorized staff and business associates.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedure to ensure an allegation of physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) was reported to California Department of Public Health (CDPH), local law enforcement, and Ombudsman (an official appointed to investigate individuals' complaints against the facility) within two (2) hours for one (1) of 1 sampled residents (Resident 8) reviewed for abuse. This deficient practice had the potential to under report allegations of abuse and placed Resident 1 at risk for further abuse. Findings: During a review of Resident 8's admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE], with the diagnoses including but not limited to schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]), and cellulitis (an infection of the deeper layers of skin and the underlying tissue) of left lower limb. During a review of Resident 8's Minimum Data Set (MDS, a resident's assessment tool), dated 11/12/2025, the MDS indicated Resident 8's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower/bathing self, sitting to standing, and walking ten feet. During a record review of Resident 8's Care Plan, dated 1/27/2026, the Care Plan indicated Resident 8 had an allegation that he was struck by a shadow a month ago. The nursing staff interventions were to closely monitor the resident's whereabouts through visual checks, room visits every two hours and as needed to ensure safety and assess comfort and needs and follow abuse prohibition protocol. During a record review of Resident 8's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 1/26/2026, the SBAR indicated Resident 8 stated during interview with surveyor (SV) that one month ago, someone struck him on his rib and he only saw a shadow. During a concurrent observation and interview on 1/26/2026 at 10:04 AM in Resident 8's room, Resident 8 was sitting on the side of his bed. Resident 8 stated a month ago (unable to recall exact date) someone hit him really hard and cracked his ribs. Resident 8 stated he was sitting on his bed just as he was doing at the moment and reading when someone hit him really hard and cracked his ribs. Resident 8 stated he did not see who hit him on his right ribs but only saw a shadow. During an interview on 1/26/2026 at 10:27 AM with the Administrator (ADM) and Director of Nursing (DON), SV informed ADM and DON Resident 8 stated an allegation of abuse. SV informed ADM and DON that Resident 8 stated someone had hit him on his right ribs but did not see who it was and that he only saw a shadow. During an interview on 1/27/2026 at 3:33 PM with the DON, the DON stated Resident 8 stated he was struck by a shadow. The DON stated Resident 8 stated he could not continue the conversation since he was going to strike out at the DON. During an interview on 1/27/2026 at 4:12 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated on 1/26/2026, Resident 8 stated he was struck by a shadow on his right side. RNS 1 stated the DON was notified of Resident 8's allegation. During an interview on 1/27/2026 at 4:48 PM with the DON, the DON stated an allegation of abuse when there is actual harm from a staff member hitting a resident would be reported to the ADM who was the abuse coordinator. The DON stated an SOC 341 (Report of Suspected Dependent Adult/Elder Abuse form) would be completed and sent to the California Department of Public Health, Ombudsman, and police. The DON stated that SV had reported to DON and ADM that Resident 8 stated someone hit him but did not see who it was and only saw a shadow. The DON stated the facility did not report the allegation since Resident 8 stated a (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shadow struck him. The DON stated she should have reported the allegation of abuse since striking was physical abuse. The DON stated that when there is an allegation of abuse the ADM is informed and an SOC 341 is sent to CDPH, Ombudsman, and the police department. The DON stated the DON was thinking it was Resident 8's mentation and behavior given his mental diagnosis and illness and therefore did not report his allegation of abuse. During a concurrent interview and record review on 1/29/2026 at 10:26 AM with the DON of the facility's policy and procedure (P&P), the DON stated any allegation of abuse should be reported within two hours. The DON stated based on the P&P all reports of resident abuse are reported are reported to local, state and federal agencies within two hours of an allegation involving abuse. During an interview on 1/29/2026 at 2:30 PM with the Administrator (ADM), the ADM stated the facility did not and should have reported the allegation of abuse for Resident 8 when they were informed on 1/26/2026. During a record review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated all reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; e. Law enforcement officials. Immediately is defined as within two hours of an allegation involving abuse. Notices include the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.).		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a coordination for a Level II Preadmission Screening and Resident Review Assessment (Level II PASRR, comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has mental disorder [MD], intellectual disability [ID] or a related condition, and determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs) was completed within 24 hours for a resident with a positive (individuals who have or are suspected to have MD, ID or a related condition) Level 1 PASRR (initial screening for possible serious MD, ID, and related conditions) for one (1) of three (3) sampled residents (Resident 60) reviewed for PASARR, in accordance with the facility policy. This deficient practice had the potential for Resident 60 to be inappropriately placed in the nursing home and not receive the necessary and appropriate psychiatric (of or relating to the study of mental illness) treatment and evaluation. Findings: During a review of Resident 60's admission Record, the admission record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to Huntington's disease (affects movements, thinking ability and mental health caused by decay of nerve cells in the brain), dementia (progressive brain disorder that slowly destroys memory and thinking skills), schizoaffective disorder (a mental illness that causes loss of contact with reality), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 60's PASRR Level I Screening, dated 8/6/2025, the record indicated the PASRR Level I was positive for serious mental illness. During a review of Resident 60's Care Plan, dated 11/25/2025, the Care Plan indicated Resident 60 had mental illness/psychosis (relating to mental illness or its treatment) diagnosis of schizoaffective disorder manifested by disorganized behavior laughing or shouting inappropriate for no apparent reason, making strange voices or faces as well as repetitive spontaneous purposeless body movements. The care plan also indicated the nursing staff interventions were to identify issues that may trigger behavioral manifestations, inform the physician with any changes in behavior, and refer to psychiatric services as needed. During a record review of Resident 60's Minimum Data Set (MDS, a resident assessment and tool), dated 12/1/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 60 had a psychiatric (relating to mental illness or its treatment)/mood disorder and was taking antipsychotic (drugs that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations [an experience which a person sees, hears, feels, or smells something that does not exist], delusions [believed to be true or real but is actually false or unreal], and disordered thinking) and antianxiety (drugs used to treat anxiety [a feeling of nervousness, panic, and fear] and related conditions) medications. The MDS also indicated Resident 60 did not have any mood and behaviors. During a review of Resident 60's Physician Order Summary Report, dated 1/14/2026, the Physician Order Summary Report indicated the following medications: clonazepam (drug used to treat panic disorder) oral tablet disintegrating 0.5 milligram (mg, unit of measurement) and haloperidol (drug used to treat mental disorders and behavioral issues related to them including agitation and an irritable mood) oral Tablet 2 mg. During an interview on 1/28/2025 at 11:16 AM with Social Services Assistant (SSA), SSA stated the latest PASRR for Resident 60 was completed on 8/6/2025. SSA stated Resident 60's Level I PASRR was positive, and the facility should have ensured within 24 hours, the need for a Level II was coordinated with the Contractor so Resident 60 could be evaluated as indicated in the facility's policy. During an interview on 1/29/2026 at 10:02 AM with the Director of Nursing (DON), the DON stated a Level II PASRR needed to be completed when the Level I PASRR was positive in order for the facility to identify if the facility was the proper placement for the resident based on Resident 60's medical diagnosis. During a review of the facility's (continued on next page)		

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Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/29/2026
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy and Procedure (P&P) titled, Preadmission Screening & Resident Review (PASRR), revised 11/30/2023, the P&P indicated if Level I Screen is positive, individual will be referred for further Level II Evaluation to ensure appropriate placement of individuals in the least restrictive setting that best meets their needs and identify the need for specialized services (PASRR Determination). The P&P indicated the facility will participate in the initial assessment process within 24 hours of submitting the completed Level I Screening or upon request of the Level II Contractor and coordinate with the Level II Contractor to ensure the PASRR process is completed before admitting the individual to the facility.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of 19 sampled residents (Resident 19 and Resident 24) received treatment and care in accordance with its Policy and Procedure (P&P) by failing to: Assess and obtain treatment for Resident 102's itch and peeling skin. Assess and obtain treatment for Resident 7's thick, brittle, and discolored nails. This deficient practice has the potential to cause complications such as infection and hospitalization of Residents 102 and 7. Findings: 1. During a review of Resident 102's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of fracture (broken bone) of upper and lower right fibula (the outer and usually smaller of the two bones between the knee and the ankle in humans) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 102's History and Physical (H&P), dated 1/21/2026, the H&P indicated the resident was alert and oriented times four (4) (person, place, time and situation). During a concurrent observation and interview on 1/26/2026 at 10:03 AM in Resident 102's room, Resident 102 was in bed scratching her left arm. Resident 102's arm was observed with skin discoloration, scars, and peeling of skin. Resident 102 stated her left arm was itchy and the nurses were not applying anything to relieve the itch. During an observation on 1/26/2026 at 12 PM in Resident 102's room, Resident 102 was observed showing and telling Certified Nursing Assistant 1 (CNA 1) that her arm itched. During an interview on 1/28/2026 at 8:11 AM, CNA 2 stated Resident 102's arm had skin discoloration, scars, and peeling of skin since admission. During a concurrent observation and interview on 1/28/2026 at 8:24 AM in Resident 102's room, Treatment Nurse 1 (TN 1) observed Resident 102 scratching her arm. TN 1 stated that if Resident 102's arm was itchy, a Change of Condition (COC-a deviation from a person's established physical, mental, or functional baseline that requires assessment, intervention, and potential revision of their care plan) form would need to be completed and the physician informed so the resident could receive treatment. TN 1 also stated he had not been informed that Resident 102's arm itched. During the same interview with TN 1 on 1/28/2026 at 8:24 AM, Resident 102's current physician orders, dated 1/2026, were reviewed. TN 1 stated that Resident 102's physician orders did not indicate a treatment for her arm itching and that there should be a treatment to prevent Resident 102 from scratching, otherwise, it could lead to infection. During an interview on 1/28/2026 at 8:36AM, the Director of Nursing (DON) stated the CNA would need to report the skin condition of the resident to the licensed nurse, and the licensed nurse will call the doctor for a treatment order and monitor for skin breakdown. During an interview on 1/29/2026 at 2:57 PM, the facility's P&P titled, Care of Skin Tears - Abrasion and Minor Breaks, revised 9/2013, the P&P indicated to obtain a physician's order. During a review of the facility's undated P&P titled, Skin observations, body mapping, and reporting of skin changes, the P&P indicated CNAs must report findings to the licensed nurse as soon as observed and follow facility reporting protocols. 2. During a review of Resident 7's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing) and muscle weakness. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2026, the MDS indicated the resident was moderately impaired (decisions poor; cues/supervision required) in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 7 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helper is required for the resident to complete the activity) on the staff with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 1/26/2026 at 1:30PM in Resident 7's room, Resident 7 was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in bed resting. Resident 7's nails were noted with yellow and brown discoloration, thick, and brittle. During a concurrent observation in Resident 7's room and interview with CNA 3 and Licensed Vocational Nurse 3 (LVN 3) on 1/28/2026 at 3:50 PM, CNA 3 and LVN 3 stated they had never seen Resident 7's nails because her hands were usually closed in a fist. However, Resident 7's nails were observed during Restorative Nursing Assistant (RNA, received additional training to support residents in maintaining or improving their functional abilities with a focus on rehabilitative care, helping with activities designed to enhance mobility, independence, and daily living) services. CNA3 and LVN 3 stated Resident 7's nails are thick, brittle, and discolored. During an interview on 1/28/2026 at 4 PM, the DON stated Resident 7's thickened, brittle and discolored nails did not and should have had a treatment order because this could be a nail fungus (a common infection caused by fungi [including yeasts, molds, and dermatophytes {causes infection of the skin, hair, and nails}] that invade the nail bed and plate, resulting in thickened, brittle, crumbly, or discolored {yellow/brown} nails) that can spread. During an interview on 1/29/2026 at 11:07 AM, LVN 2 stated when she observes thick yellow and brown nails on a resident, she would call the doctor to obtain an order because it could be a fungus. LVN 2 also stated the nails need to be addressed because the infection can spread to other nails. During an interview on 1/29/2026 at 1:48 PM, the Quality Assurance Nurse (QAN) stated thickened nails with yellow and brown discoloration should be assessed and reported to the physician after assessment. QAN also stated fungus can spread to other nails if not addressed. During an interview on 1/29/2026 at 2:33 PM, the DON stated resident's thickened, brittle, or discolored nails should be reported to the licensed nurse so the physician could be notified, and treatment can be obtained as necessary to prevent complications. During a review of the facility's undated P&P titled, Care of Nails, the P&P indicated to maintain cleanliness, prevent infection or resident injury and to improve resident's self-image. The P&P also indicated to report any unusual observations to licensed nurse for follow up.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services for one (1) of 1 sampled residents (Resident 60) reviewed for catheter (indwelling catheter, tube inserted into the bladder to drain urine into a drainage bag) by failing to assess, monitor, and document signs and symptoms (s/sx) of urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder [organ that stores urine] or urethra [the tube through which urine leave the body]) as indicated in the physician's order and care plan and to keep the indwelling catheter bag off the floor as indicated in the facility's Urinary Catheter Care Policy and Procedure (P&P). These deficient practices had the potential to result in delayed UTI identification, delayed treatment, worsening infection, and hospitalization. Findings: During a review of Resident 60's admission Record, the admission record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to urinary tract infection, obstructive (blockage in the urinary tract that impedes urine flow) and reflux (the backward flow or urine from the bladder into the kidneys) uropathy, and benign prostatic hyperplasia (BPH, non-cancerous prostate gland enlargement that can cause urination difficulty), and Extended Spectrum Beta-Lactamase (ESBL, a group of bacteria that cause infections in healthcare settings and communities that resist effects of common antibiotics). During a record review of Resident 60's Minimum Data Set (MDS, resident assessment tool), dated 12/1/2025, the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 60's required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene. The MDS also indicated Resident 60 had an indwelling catheter. During a record review of Resident 60's Order Summary Report, dated 1/14/2026, the Order Summary Report indicated the following physician orders: May flush catheter with 150 cubic centimeter (cc, unit of volume) normal saline (NS, mixture of salt and water used to replenish fluid and electrolyte) for hematuria (blood in the urine), sediments (microscopic gritty particles or mucus in the urine) and cloudiness as needed. Monitor urine for sediments, cloudiness, hematuria and chart: S = sediments; C = cloudiness; H = hematuria and O = clear every shift. During a record review of Resident 60's Care Plan, dated 11/25/2025, the Care Plan indicated Resident 60 was at risk for urinary elimination problem, urinary return, acute pain, fluid volume deficit, UTI related to BPH. The staff interventions were to monitor s/sx of UTI such as hematuria, cloudy urine, burning sensation, foul smelling urine, flank pain, elevated temperature, and to notify physician if present. During a record review of Resident 60's Care Plan, dated 12/1/2025, the Care Plan indicated Resident 60 had an indwelling foley catheter for urinary retention (condition that makes it difficult to empty the bladder, either partially or completely). The staff interventions were to monitor urine for sediment, cloudiness, odor, blood, and amount every shift and to report to physician if any. It also included to observe for signs of UTI like presence of strong odor, dark colored urine, hematuria, weakness, elevated temperature, and sudden change in level of consciousness. During an observation on 1/26/2026 at 9:27 AM in Resident 60's room, Resident 60's indwelling catheter bag was touching the floor. During an observation on 1/26/2026 at 11:22 AM in Resident 60's room, Resident 60's indwelling catheter bag was touching the floor. During an observation on 1/26/2026 at 3:46 PM in Resident 60's room, Resident 60's indwelling catheter bag was touching the floor. During an observation on 1/27/2026 at 10:24 AM in Resident 60's room, Resident 60's indwelling catheter tubing had a minimal amount of sediment noted in the indwelling catheter. During a record review of Resident 60's TAR for the month of January 2026, the TAR indicated the following for the monitoring of urine for sediments, cloudiness, hematuria (S = sediments; C = cloudiness; H = hematuria and O = clear): On 1/27/2026, O was documented for all three shifts. On 1/28/2026, I was documented for Day shift. During an observation on 1/28/2026 at (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:24 AM in Resident 60's room, Resident 60's indwelling catheter tubing had cloudy urine with scant pink tinge color. During an observation on 1/28/2026 at 2:39 PM in Resident 60's room, Resident 60's indwelling catheter tubing had cloudy urine with pink tinge color and minimal sediments. During a concurrent observation and interview on 1/28/2026 at 2:43 PM in Resident 60's room with the Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 60's indwelling foley catheter tubing had urine which was very dark in color, looked concentrated, with some particles with a tinge of pink. RNS 1 stated Resident 60 usually did not have particles in his indwelling catheter. RNS 1 stated Resident 60 was at a higher risk for infection, and it was best to inform the physician based on the urine assessment to determine the appropriate treatment for the resident. During a concurrent interview and review on 1/28/2026 at 3 PM with RNS 1 of Resident 60's Treatment Administration Record (TAR, a medical record used by healthcare providers to document the administration of a treatment) and Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication), RNS 1 stated there was no documentation of Resident 60's hematuria, presence of sediments, or any interventions performed, such as flushing the catheter. During a concurrent interview and record review on 1/28/2026 at 3:43 PM with RNS 1 of Resident 60's Nurses' notes, RNS 1 stated there was no documentation of Resident 60's urine assessment on 1/27/2026 and 1/28/2026 AM shift. During a concurrent interview and review on 1/28/2026 at 3:54 PM with Licensed Vocational Nurse 7 (LVN 7) of Resident 60's Care Plan, LVN 7 stated on 1/27/2026, around 2 PM, LVN 7 observed moderate white sediments in the tubing of Resident 60's indwelling catheter. LVN 7 further stated that at 2:30 PM, she noticed scant hematuria in the indwelling catheter and informed the Treatment Nurse to flush it. LVN 7 stated she would notify the physician if the hematuria in the indwelling catheter remained unresolved. LVN 7 also stated Resident 60 had a history of UTI and had previously received antibiotics (a drug used to kill bacteria and treat infections) for UTIs. LVN 7 stated Resident 60's Care Plan indicated staff needed to monitor for sediment, cloudiness, odor, blood, and amount every shift and report the findings to the physician. LVN 7 stated she only flushed the indwelling catheter and did not report the urine assessments to the physician. During a concurrent observation and interview on 1/29/2026 at 10:13 AM with the Director of Nursing (DON) of Resident 60's indwelling catheter bag on 1/26/2026, the DON stated Resident 60's indwelling catheter bag was touching the floor. A concurrent interview and review with the DON of Resident 60's Care Plan and Medical Records, the DON stated a resident's indwelling catheter bag should not be touching the floor to prevent infections. The DON stated staff were supposed to monitor the urine for presence of blood, cloudiness, and sediments. The DON stated the purpose of monitoring urine was to assess for abnormal characteristics such any sediments or cloudiness which could indicate a possible infection and should be reported to the physician. The DON stated staff should flush the indwelling catheter, document the flush, and contact the physician when sediments are noted in the indwelling catheter. The DON stated notifying the physician is necessary because this could signify a possible infection. The DON stated Resident 60's care plan interventions were to monitor urine for sediment, cloudiness, odor, blood, and amount every shift and report to physician if any. The DON also stated Resident 60's Medical Records did not indicate that the physician was notified of Resident 60's sediment in the indwelling catheter. During a record review of the facility's P&P titled, Urinary Catheter Care, revised 08/2022, the P&P indicated to be sure the catheter tubing and drainage bag are kept off the floor. The P&P also indicated observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately: if the urine has an unusual appearance (i.e., color, blood etc.); and if signs and symptoms of urinary tract or urinary retention occur.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 60) reviewed for tube feeding (gastrostomy tubes [GT- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration]) receive appropriate treatment and services by failing to properly label Resident 60's GT formula bag with licensed nurse's initials, date, and time the formula was hung/administered as indicated on the facility policy. This deficient practice placed Resident 60 at risk for not receiving the correct tube feeding and amount per physician's order, which could lead to complications such as weight loss and fluid overload (an excess of fluid in the body). Findings: During a review of Resident 60's admission Record, the admission record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to Huntington's Disease (affects movements, thinking ability and mental health caused by decay of nerve cells in the brain), dementia (progressive brain disorder that slowly destroys memory and thinking skills), schizoaffective disorder (a mental illness that causes loss of contact with reality), and gastrostomy status. During a record review of Resident 60's Minimum Data Set (MDS, a resident assessment and tool), dated 12/1/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making is severely impaired. The MDS indicated Resident 60's functional ability for eating was not attempted due to medical conditions or safety concerns. The MDS indicated Resident 60 had a feeding tube and received more than 51% of total calories through tube feeding. During a record review of Resident 60's Order Summary Report, dated 1/14/2026, the Order Summary Report indicated the following physician orders: Enteral feed (method of delivering nutrients directly into the stomach or small intestine via a tube) order every day shift enteral feed order: Provide Nutren 2.0 (a calorically dense complete nutrition tube feeding formula) at 45 milliliters (ml, unit of measurement)/hour (hr) for 20 hours via Kangaroo Pump (a portable enteral feeding pump designed for delivering nutrition to residents who cannot consume food orally) (to provide 900 ml/1800 kilocalories [kcal, unit of energy]/24 hours) with water flushes of 50 ml/hr for 20 hr/day. Start at 1 PM and off at 9 AM or until total dose of volume is completed. During an observation on 1/27/2026 at 10:15 AM in Resident 60's room, Resident 60 was in bed with a GT connected to a pump with a formula that was running at 45 ml/hr. The GT feeding formula bag was not labeled. It did not indicate the Patient's Name, Patient ID, Date/Time Started, and Tube Feeding Order. During a concurrent observation and interview on 1/27/2026 at 10:38 AM in Resident 60's room with Licensed Vocational Nurse 1 (LVN 1), Resident 60 was observed in bed with a GT. Resident 60's GT formula bag was hung and running at 45 ml/hr. LVN 1 stated that Resident 60's GT formula bag was not labeled and should be labeled with the time, date, feeding rate, and licensed nurse's initials, as indicated on the facility's policy. During an interview on 1/29/2026 at 10:11 AM with the Director of Nursing (DON), the DON stated licensed nurses are required to label the formula bag to ensure they administer the resident's feeding according to the physician's order. The DON stated that when formula bags are not labeled, there is a possibility that licensed nurses could provide the wrong feeding and deliver an incorrect feeding rate to residents. During a concurrent review of the facility's policy and procedure (P&P) for enteral feedings with the DON on 1/29/2026 at 10:11 AM, the DON stated that before administering the enteral feeding, the licensed nurses need to check the resident's name, formula label, initials, date and time the formula was hung, and cross-reference it with the physician's order to ensure the formula was administered correctly. During a review of the facility's P&P titled, Enteral Feedings - Safety Precautions, revised 5/2014, the P&P indicated to check the enteral nutrition label against the order before administration. Check the following information: Resident name, ID and room number; Type of formula; Date and time (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	formula was prepared; Route of delivery; Access site; Method (pump, gravity, syringe); and Rate of administration (milliliter/hour). On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services for one (1) of 1 sampled resident (Resident 11) reviewed for dialysis (the medical necessity for ongoing removal of waste and excess fluid from the blood to sustain life due to permanent kidney failure) by failing to: Monitor Resident 11's fluid intake weekly and follow the physician's order for fluid restriction of 1200 milliliters (ml- unit of measurement for volume) a day. Develop a resident-centered comprehensive care plan (a care plan developed and implemented to meet the resident's preferences and goals, and addresses the resident's medical, physical, mental, and psychosocial needs) for Resident 11 who was on fluid restriction. This deficient practice had the potential to place Resident 11 at risk for fluid overload (when the body has too much water leading to swelling, high blood pressure, shortness of breath, and heart strain). Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included end stage renal disease (condition where the kidneys have permanently stopped working and can no longer function at a level needed to sustain life), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and heart failure (when the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs). During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 11 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort) with eating, oral/personal hygiene, and upper/lower body dressing. The MDS indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, rolling left and right, sit to stand, and sit to lying. The MDS indicated Resident 11 was on dialysis. During a review of Resident 11's Order Summary Report, dated 1/29/2026, the Order Summary Report indicated a physician order with a start date of 9/21/2025 for: Fluid restriction: 1200 ml per day Nursing: 7-3= 180 ml, 3-11= 180 ml, 11-7= 120 ml and Dietary: 720 ml (breakfast=240 ml, lunch=240 ml, dinner= 240 ml) Every shift for fluid restriction During a review of Resident 11's Medication Administration Record (MAR), dated 1/1/2026 to 1/31/2026, the MAR indicated the following fluid intake for Resident 11 from Nursing: On 1/4/2026: 7-3= 660 ml, 3-11= 240 ml, 11-7= 120 ml (total of 1020 ml) On 1/11/2026: 7-3= 600 ml, 3-11= 240 ml, 11-7= 120 ml (total of 960 ml) On 1/18/2026: 7-3= 660 ml, 3-11= 240 ml, 11-7= 120 ml (total of 1020 ml) On 1/19/2026: 7-3= 660 ml, 3-11= 240 ml, 11-7= 120 ml (total of 1020 ml) During a review of Resident 11's Nutrition-Fluids form, from 1/1/2026 to 1/29/2026, the Nutrition-Fluids form indicated the following fluid intake for Resident 11 from Dietary: On 1/4/2026: 120 ml at 1: 52 PM and 120 ml at 10:59 PM (total of 240 ml) On 1/11/2026: 10 ml at 12:18 AM, 120 ml at 2:04 PM, 260 ml at 6:10 PM, and 260 ml at 11:49 PM (total of 960 ml) On 1/18/2026: 120 ml at 6:59 AM, 240 ml at 11:41 AM, and 260 ml at 6:44 PM (total of 620 ml) On 1/19/2026: 12 ml at 6:59 AM, 180 ml at 12:03 PM, and 260 ml at 6:10 PM (total of 452 ml) During an interview, on 1/28/2026, at 2:33 PM, with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated he was assigned to Resident 11 today. CNA 4 stated Resident 11 goes to dialysis three times a day. CNA 4 stated he did not know that Resident 11 was on fluid restriction. CNA 4 stated he did not know how much fluid Resident 11 was allowed to take during his shift. During an interview, on 1/29/2026, at 2:06 PM, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 11 was on dialysis and had a physician's order to be on a 1200 ml fluid restriction per day. LVN 4 stated it was important to assess Resident 11's fluid intake to make sure he is getting adequate fluids and at the same time, does not go over 1200 ml. LVN 4 stated the amount of fluid Resident 11 drinks during medication administration was documented in Resident 11's MAR. LVN 4 stated CNAs also document Resident (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11's fluid intake with his meals in the Nutrition-Fluids form. LVN 4 stated she did not know if Resident 11's total fluid intake was added and totaled at the end of the day. LVN 4 stated drinking more than 1200 ml can cause Resident 11 to go into fluid overload which can cause edema, shortness of breath, and affect his organs. During a concurrent interview and record review, on 1/29/2026, at 2:06 PM, with LVN 4, Resident 11's care plan, dated 9/22/2025, for hemodialysis was reviewed. LVN 4 stated a care plan reflects a problem, goal, and interventions on how to reach the goal. LVN 4 stated Resident 11's hemodialysis care plan indicated Resident 11 was on a 1200 ml a day fluid restriction. LVN 4 stated Resident 11's hemodialysis care plan only had an intervention to take vital signs pre and post dialysis days. LVN 4 stated the care plan did not include interventions addressing Resident 11's fluid restriction. LVN 4 stated Resident 11's care plan goal for hemodialysis indicated that Resident 11 will not have complications related to hemodialysis daily, if not at all, until the next review, in three months. LVN 4 stated Resident 11's care plan goal will not be met if all the proper interventions to prevent fluid overload were not included. LVN 4 stated it was the responsibility of all licensed nurses to make sure the care plan interventions were complete. During an interview, on 1/29/2026, at 3:03 PM, with the Director of Nursing (DON), the DON stated Resident 11 was on a 1200 ml a day fluid restriction because he was on dialysis and his kidneys were no longer functioning. The DON stated it was important for facility staff to make sure Resident 11's fluid restriction order was followed to prevent Resident 11 from going into fluid overload. The DON stated the CNAs and LVNs documented Resident 11's daily fluid intake separately on the MAR and Nutritional Fluids. The DON stated the licensed nurses did not assess Resident 11's weekly fluid intake because the total fluids documented on the MAR and Nutritional Fluids were not added up to ensure Resident 11's fluid intake does not go over 1200 ml a day as indicated on the physician's order. The DON stated the facility's policy was for hemodialysis and fluid restriction was not followed. During the same concurrent interview and record review, on 1/29/2026, at 3:03 PM with the DON, Resident 11's care plan for hemodialysis, dated 9/22/2025 was reviewed. The DON stated Resident 11's care plan addressing his fluid restriction was not comprehensive and individualized because it only indicated to check Resident 11's vital signs before and after dialysis. The DON stated the care plan should have included interventions addressing Resident 11's fluid restriction and how to prevent fluid overload. The DON stated it was important to have a comprehensive (complete) and individualized care plan to make sure the proper care was provided for the residents. The DON stated the care plan policy was not followed. During a review of the facility's policy and procedure (P&P), titled, Fluid Restriction, revised 3/2022, the P&P indicated the following: The facility will provide a method to ensure fluid intake is restricted as ordered by the physician while maintaining optimum hydration to the extent possible. To allow for fluid intake throughout the day in accordance with fluid restriction orders. The licensed nurse receiving the order for a fluid restriction will make a care plan entry. Nursing will place the Resident on intake and output monitoring to ensure parameters of fluid intake are adhered to. Resident assessments of fluid intake will be completed by a licensed nurse on a weekly basis and as needed. During a review of the facility's P&P, titled, Dialysis Care, revised 3/2022, the P&P indicated that, dialysis diets, including fluid restrictions shall be provided as prescribed by the physician. The P&P also indicated that, Licensed nurses shall monitor resident's compliance with dialysis diets, including fluid restrictions. During a review of the facility's P&P, titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the following: 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 comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflects currently recognized standards of practice for problem areas and conditions. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.		

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 01/29/2026
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 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** Based on observation, interview, and record review the facility failed to ensure safe provision of pharmaceutical services as indicated in the facility policy by failing to refrigerate one unopened insulin (a hormone made by the pancreas [sits behind the stomach in the upper abdomen that plays a key role in both digestion and blood sugar regulation] that acts like a key so it can be used for energy, effectively lowering blood sugar levels after eating) vial for Resident 108, in accordance with the facility policy. This deficient practice increases the risk of Resident 108 receiving a medication that had become ineffective or toxic due to improper storage, possibly leading to health complications resulting in hospitalization or death. Findings: During a review of Resident 108's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following but not limited to diagnoses of hypertensive (HTN - high blood pressure) chronic kidney disease (long-term, progressive, and irreversible loss of kidney function), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and cerebral infarction (a critical medical condition where restricted blood flow causes tissue death [necrosis] in the brain affecting the left side). During a review of Resident 108's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident is awake, alert and oriented times 1 (by person). During a review of the Resident 108's Physician Order, dated 1/28/2026, the Physician Order indicated Humalog (medication to manage blood sugar) Injection Solution 100 unit/milliliters (ml - unit of measure). Inject as per sliding scale. If blood sugar level is 401 or greater, give 8 units and call physician. Subcutaneously (under the skin) before meals and at bedtime for DM type 2. Rotate injection sites. During an observation and interview on 1/29/2026 at 11:40 AM, Resident 108's unopened (1) insulin vial Humalog 100 unit/ml was observed inside the medication cart. Licensed Vocational Nurse 2 (LVN 2) stated if it is unopened, it needs to be refrigerated because it can affect the potency (strength of a drug or substance in producing its desired effect at a given dose) of insulin. LVN 2 also stated she would need to discard the insulin and order another insulin vial from the pharmacy. During an interview with the Director of Nursing (DON) on 1/29/2026 at 11:50AM, the facility's Policy and Procedure (P&P) titled, Storage of Medications, revised 11/2020, was reviewed. The DON stated if an insulin vial is unopened, it should be stored in the fridge until it is opened. DON also stated it will affect the potency of the insulin (a vital hormone produced by the pancreas that regulates blood sugar [glucose] levels by allowing cells to absorb glucose from the bloodstream for energy) and may not be effective for the resident. During a review of the facility's P&P titled, Storage of Medications, revised 11/2020, the P&P indicated medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. During a review of the facility's undated P&P titled, Insulin Storage, labeling and handling (Vials and Pens), the P&P indicated unopened insulin shall be stored in a medication refrigerator maintained at 36 degrees Fahrenheit to 46 degrees Fahrenheit.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed provide accurate documentation of treatment done for one (1) of 19 sampled residents (Resident 9) in accordance with professional standards (the expectations, guidelines, and rules that individuals in a particular profession must follow to maintain quality, ethics, and safety in their work) and practices by failing to transcribe physician's order for Resident 9's oxygen administration from Hospice (a program that gives special care to residents who are near the end of life and have stopped treatment to cure or control their disease) agency order to the resident's physician's order in the facility records. This deficient practice had the potential to affect the accuracy of clinical assessments and medical management for Resident 9. Findings: During a review of Resident 9's admission Record, the admission record indicated Resident 9 was admitted to the facility on [DATE], with the diagnoses including but not limited to dependence of supplemental oxygen (a medical state that requires an external, higher than normal concentration of oxygen to maintain adequate blood oxygen levels due to chronic lung/heart disease), encounter for palliative care (specialized form of care that provides symptom relief, comfort, and support to people living with serious or chronic illness), and metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function). During a record review of Resident 9's Hospice Medication List (from hospice agency) dated from 8/14/2025 to 12/31/2025, it indicated the following orders: On 8/14/2025, oxygen 2 liters per minute (LPM or l/min, volume of oxygen supplied over a period of time) inhaled continuously for shortness of breath. On 12/31/2025, oxygen 2 liter/minute intranasally (administered through the nose) continuously for shortness of breath. During a record review of Resident 9's Order Summary Report, dated 8/15/2025, the order indicated administer oxygen at 2 liter/minute via nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostrils) for shortness of breath as needed to maintain oxygen saturation 92% and above. During a record review of Resident 9's Minimum Data Set (MDS, a resident assessment and tool), dated 11/19/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 9 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing self, and personal hygiene. The MDS indicated Resident 9 did not have respiratory treatments or oxygen therapy. During an observation on 1/28/2026 at 9:05 AM in Resident 9's room, Resident 9 was observed with oxygen via nasal cannula at 2 LPM. During an interview on 1/28/2026 at 10:40 AM with the Director of Nursing (DON), the DON stated the licensed nurse would transcribe the order from the physician's Hospice orders onto the facility's electronic physician's orders that will reflect in the resident's Order Summary Report. During the same concurrent interview record review with the DON on 1/28/2026 at 10:40 AM, Resident 9's current Hospice orders dated from 8/14/2025 to 12/31/2025 and Resident 9's current Order Summary Report from the facility for the month of January 2026 were reviewed. The DON stated, the hospice orders indicated to administer oxygen at 2 l/min intranasally continuously for shortness of breath and Resident 9's current Order Summary Report from the facility indicated administer oxygen at 2 liter/minute via nasal cannula for shortness of breath as needed to maintain oxygen saturation 92% and above. The DON stated the orders were not the same since the facility's order indicated the oxygen order was provided as needed and the Hospice orders were to administer oxygen continuously. The DON stated the order was not transcribed correctly to Resident 9's physician orders and should be transcribed from the Hospice order so the residents would have the right and accurate treatment/ oxygen therapy. The DON stated licenses nurses has been giving Reisdent 9's oxygen via nasal cannula continuously and Reisdent 9's physician's order for the oxygen was incorrectly entered as as needed only. During a record review of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's P&P titled, Charting and Documentation, revised 07/2017, the P&P indicated documentation in the medical record will be objective, complete, and accurate.		