STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055685	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIGHTON PLACE SPRING VALLEY	9009 CAMPO ROAD SPRING VALLEY, CA 91977

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent for treatment and the use of a psychotherapeutic (drugs that affect mood and behavior, used to treat mental disorders) medication for one of three closed record residents (5) reviewed for signed consent. This failure had the potential for the resident to be unable to make an informed decision regarding treatment and the use of the psychotherapeutic medication. Findings: Resident 5 was admitted to the facility on [DATE]. and was her own responsible party, per the facility's Face Sheet. A review of Resident 5's medical record was conducted on 2/27/20. Per Resident 5's Cognitive Loss care plan, the resident was alert and oriented to person, place and time. Resident 5's Consent To Treat document, dated 5/16/19, had not been signed by the resident. An admission physician's orders [REDACTED]. A review of Resident 5's MAR indicated [REDACTED]. The Informed Consent document for [MEDICATION NAME] had not been signed by Resident 5 or the physician. On 2/27/20 at 1:30 P.M., a concurrent interview and record review of Resident 5's medical record was conducted with LN 1. LN 1 noted Resident 5's Consent To Treat document had not been signed. LN 1 stated Resident 5 should not have been treated without the signed consent. LN 1 stated [MEDICATION NAME] required a signed informed consent, by the resident. LN 1 stated Resident 5 had received [MEDICATION NAME] two times daily from 5/17/19 - 5/18/19 and once on 5/19/19 without signed consent and it should have been signed prior to the drug being administered. LN 1 stated this would have been important to ensure the resident was made aware of the risks and benefits involved with the medication. LN 1 stated Resident 5 had not been given the right to decide if she wanted the medication or not. On 2/27/20 at 2:15 P.M., a concurrent interview and review of Resident 5's medical record was conducted with the DON. The DON noted Resident 5's Consent To Treat document had not been signed prior to treatment and stated it should have been. The DON noted Resident 5's Informed Consent document for [MEDICATION NAME] had not been signed prior to the drug being administered and stated it should have been. The DON stated Resident 5 had not been made aware of the risks and benefits of the medication and had not been given the right to decide if she wanted the medication or not. Per the facility document titled Informed Consent, revised July 2016, .It is the policy of this Facility to include residents in their care decisions by facilitating information and obtaining informed consent for [MEDICAL CONDITION] medications .
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a completed written notice of transfer and discharge to one of three closed record residents reviewed for discharge. As a result, the resident was not made aware in writing of the reason for the discharge and was not made aware of her right to appeal the discharge. Findings: Resident 5 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Resident 5 was discharged from the facility on 5/19/19, per the facility's Face Sheet. On 2/28/20 at 2:40 P.M., a concurrent interview and review of Resident 5's medical record was conducted with the SSD. The SSD stated when a resident is discharged from the facility, they or their RP signs the Notice of Proposed Transfer and Discharge document after it is explained. The Notice of Proposed Transfer and Discharge, dated 5/19/19, indicated patient responsible for self. The document had not been signed by Resident 5 but rather another person's printed name appeared on the Resident/Representative Signature line. The SSD stated she had not been involved in Resident 5's discharge. The SSD stated she assumed nothing had been explained to Resident 5 on discharge because the document had not been signed by Resident 5. The SSD stated there should also have been a reason for discharge and there was not. The SSD stated she did not know who signed The Notice of Proposed Transfer and Discharge. On 2/28/20 at 3 P.M., a concurrent interview and review of Resident 5's Notice of Proposed Transfer and Discharge document was conducted with LN 2. LN 2 stated she was on duty when Resident 5 was discharged . LN 2 stated she assumed everything had already been explained to Resident 5 and all she did was assist Resident 5 to the transport vehicle on discharge. LN 2 stated Resident 5 did not sign the document. LN 2 stated she, herself, printed the name of the transport driver on the signature line of The Notice of Proposed Transfer and Discharge document. Per the facility's policy titled Transfer and Discharge, revised October 2017, .B .i. The Notice of Proposed Transfer and Discharge will be signed by the resident .
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide preparation and documentation of proper discharge procedure for one of three closed record residents (5) reviewed for discharge. As a result, the resident's safety was placed at risk. Findings: Resident 5 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Resident 5 was discharged from the facility on 5/19/19, per the facility's Face Sheet. A review of Resident 5's medical record was conducted on 2/27/20. Per the Resident Admission Assessment, dated 5/16/19, Resident 5 was non ambulatory and propelled herself utilizing a wheelchair. A physician's orders [REDACTED]. No LN had documented discharge education in Resident 5's nursing notes. On 2/28/20 at 2:05 P.M., an interview was conducted with the SSD. The SSD stated she was responsible for resident discharges from the facility. The SSD stated prior to discharge she met with the resident and made arrangements for any continuing care required. The SSD stated an IDT meeting would be conducted to ensure nothing is missed. The SSD stated all discharge preparations would be documented in the resident medical record. On 2/28/20 at 2:40 P.M., a concurrent interview and review of Resident 5's medical record was conducted with the SSD. There was no documented evidence by the SSD that she had met with Resident 5 to discuss discharge, that arrangements had been made for continuing care or for medical equipment that could be needed, or that an IDT had been conducted. The SSD stated she did not prepare Resident 5's discharge. The SSD stated she assumed nothing had been discussed with or prepared for Resident 5's discharge as nothing had been documented. The SSD stated Resident 5's discharge was not a proper discharge. On 2/28/20 at 3:15 P.M., an interview was conducted with the Admin. The Admin stated all steps in the discharge process should be followed to ensure a safe discharge. The Admin stated all discharge documentation should have been in the medical record; the facility's discharge process was not followed properly. Per the facility's policy titled Transfer and Discharge, revised October 2017, .I. Discharge Planning .D. Referrals made to local contact agencies .will be documented in the medical record .G. Social Service .will communicate with .the resident .as the time for discharge approaches .H. Social Services will document the discharge planning, preparation, and the resident's post-discharge needs .III. Discharge Care Plan A .Social Services will develop a Discharge Care Plan in coordination with IDT.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE