STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555338	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIGHTON CARE CENTER	**1836 N. FAIR OAKS AVE PASADENA, CA 91103**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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 follow physician orders [REDACTED]. Resident 1 had physician orders [REDACTED]. Right hip surgical site clean with normal saline (NS, solution used to clean wounds), pat dry, and apply triple antibiotic ointment (medication to treat or prevent infection) and cover with dry dressing every day for 14 days. 2. Monitor discoloration to right upper extremity (RUE) and left upper extremity (LUE) for any changes daily for 21 days. This deficient practice had the potential for the resident to acquire an infection and/or have worsening of skin conditions not noticed. Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 12/21/17, indicated Resident 1 had moderate impairment in cognitive skills and required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff for transferring, dressing, personal hygiene, and toileting. A review of Resident 1's physician's orders [REDACTED]. Monitor discoloration to RUE and LUE for any changes daily for 21 days. A review of Resident 1's care plan titled, Fracture Care Plan, dated 12/14/17, indicated to observe skin body check daily and/or every shift. Assess for pain prior, during, and post treatment care and monitor for effectiveness of plan of care (POC). During an interview and record review on 7/15/20 at 12:58 p.m., a Medical Records (MR) stated there is no documentation in Resident 1's Treatment Administration Record (TAR) that the facility staff assessed the resident for skin discoloration or that treatment to the right hip surgical site was done. During an interview and record review on 7/15/20 at 1:19 p.m., the Director of Nursing (DON) stated if there is no documentation then treatment services were not done. A review of the facility's policy and procedure titled, Health Information Record Manual, revised date 1/21/2019, indicated medications and treatments will be administered as ordered, recorded timely, and monitored for accuracy. A review of the facility's policy and procedure titled, Medication and Treatment Orders, dated 7/2016, indicated medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 12/2016 indicated each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and/or items included in the plan of care.
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 interview and record review, the facility failed to ensure accurate documentation were complete for one of three sampled residents (Resident 1). Resident 1 did not have any documentation of treatment and/or assessment of skin discoloration changes as ordered. This deficient practice had the potential for the resident's wound to worsen unnoticed. (cross reference F684) Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 12/21/17, indicated Resident 1 had moderate impairment in cognitive skills and required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff for transferring, dressing, personal hygiene, and toileting. A review of Resident 1's physician's orders [REDACTED]. Monitor discoloration to RUE and LUE for any changes daily for 21 days. During an interview on 7/14/20 at 11:34 a.m., the Administrator stated that there was no treatment log for Resident 1's right hip surgical site. During an interview on 7/14/20 at 11:45 a.m., the Director of Nursing (DON) stated there was no documentation of treatment completed for Resident 1's right hip surgical site. The DON stated there was no skin assessments completed for Resident 1's right hip surgical site while the resident was in the facility. A review of the facility's policy and procedure, Wound Care, dated 10/2010 indicated the following information should be recorded in the resident's medical record: A. The type of wound care given. B. The date and time the wound care was given. C. The position in which the resident was placed. D. The name and title of the individual performing the wound care. E. Any change in the resident's condition. F. All assessment data (for example, wound bed color, size, draining, etcetera) obtained when inspecting the wound. G. How the resident tolerated the procedure. H. Any problems or complaints made by the resident related to the procedure. I. If the resident refused the treatment and the reason(s) why. J. The signature and title of the person recording the data. A review of the facility's policy and procedure, Charting and Documentation, dated 7/2017 indicated treatment or services performed shall be documented in the resident's medical record.

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

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.