STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Valley Post Acute	2400 Parkside Drive Fremont, CA 94536

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 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. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for Residents 1-8, the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).2. The facility failed to ensure, between 5/1/23-8/31/23, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).Findings:1. During an interview, on 4/16/26 at 9:40 a.m., Director of Nursing (DON) and Medical Record Director (MRD) were asked to describe the scheduled medication process. Their description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered to the facility. They further described that the Shipping Manifests and CDRs were retained by the facility. They were requested to provide all the scheduled medication Shipping Manifests and CDRs from 5/1/23 through 8/31/23. During a concurrent observation and interview, on 4/16/26 at 9:50 a.m., at nursing station 1, Registered Nurse (RN 1) identified medication cart (stores medication) #1. RN 1 was asked to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The nurse reviewed the scheduled medication and Shipping Manifest for errors. The nurse signed the Shipping Manifest. The Shipping Manifest was sent for retention. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medication and the CDR were sent to the DON.During a concurrent interview and record review, on 4/17/26 at 10:17 a.m., DON and MRD identified the following CDRs. Resident 1 5879782 Oxycodone (narcotic pain reliever)/APAP (acetaminophen, non-narcotic pain reliever) 5/325 mg tab (tablet) #38 8/27/23Resident 1 5914390 Oxycodone/APAP 5/325 mg tab #30 9/4/23Resident 2 5807376 Oxycodone 5 mg tablet #8 8/8/23Resident 2 5781740 Oxycodone 5 mg tablet #2 8/1/23Resident 3 5638821 Oxycodone 5 mg tablet #10 8/25/23Resident 4 5520097 Hydrocodone (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(narcotic pain reliever)/APAP 5/325 mg tab #32 5/27/23Resident 5 5437319 Hydrocodone/APAP 10/325 mg tab #38 5/9/23Resident 6 5604363 Hydrocodone/APAP 10/325 mg tab #17 6/16/23Resident 7 5709661 Hydrocodone/APAP 10/325 mg tab #12 7/13/23Resident 8 5479374 Oxycodone 5 mg tablet #36 5/18/23They stated the facility could not locate the corresponding Shipping Manifests. During a concurrent interview and record review, on 4/17/26 at 10:30 a.m., DON, Assistant Director of Nursing (ADON) and MRD identified the resident's CDRs listed below. They compared the CDR medication removal against the MAR. They acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below. Resident 6 5604363 Hydrocodone/APAP 10/325 mg tab #17 6/16/236/23/23 23407/4/23 1110Resident 7 5709661 Hydrocodone/APAP 10/325 mg tab #12 7/13/237/14/23 21007/15/23 21007/16/23 0657, 1101Resident 1 5914390 Oxycodone/APAP 5/325 mg tab #30 9/4/239/10/23 0601, 20009/12/23 05079/17/23 3 removed from CDR, 2 documented on MARResident 8 5479374 Oxycodone 5 mg tablet #36 5/18/235/22/23 2300Resident 2 5781740 Oxycodone 5 mg tablet #2 8/1/238/2/23 1110, 11108/3/23 1400, 1400During a concurrent interview and record review, on 4/17/26 at 10:59 a.m., DON, ADON and MRD identified the policy for Controlled Substances (Revision Date November 2022). They reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be complete (all documents available) and accurate (monitored and reconciled). An administrative record review, of the policy for Controlled Substances (Revision Date November 2022) showed, Dispensing and Reconciling Controlled Substances,1. Controlled substance inventory is monitored and reconciled (complete and accurate) to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records.2. During an interview, on 4/16/26 at 9:40 a.m., DON and MRD were asked to describe the scheduled medication process. Their description included that scheduled medications were delivered by the pharmacy with a corresponding Shipping Manifest. The Shipping Manifest was the documentation that the scheduled medication was delivered to the facility. They further described that the Shipping Manifests and CDRs were retained by the facility. They were requested to provide all the scheduled medication Shipping Manifests and CDRs from 5/1/23 through 8/31/23. During a concurrent observation and interview, on 4/16/26 at 9:50 a.m., at nursing station 1, RN 1 identified medication cart (stores medication) #1. RN 1 was asked to describe the scheduled medication record system. Her description included scheduled medications were delivered with a Shipping Manifest and a corresponding CDR. The nurse reviewed the scheduled medication and Shipping Manifest for errors. The nurse signed the Shipping Manifest. The Shipping Manifest was sent for retention. The medication was locked in the medication cart. The CDR was filed at the medication cart. The CDR was used to document removal of patient medications. Administration of the medication was documented on the MAR. Completed CDRs were sent for retention. If there were scheduled medications remaining upon discontinuation, the remaining medication and the CDR were sent to the DON.During a concurrent interview and record review, on 4/17/26 at 10:17 a.m., DON and MRD identified the following CDRs. Resident 1 5879782 Oxycodone (narcotic pain reliever)/APAP (acetaminophen, non-narcotic pain reliever) 5/325 mg tab (tablet) #38 8/27/23Resident 1 5914390 Oxycodone/APAP 5/325 mg tab #30 9/4/23Resident 2 5807376 Oxycodone 5 mg tablet #8 8/8/23Resident 2 5781740 Oxycodone 5 mg tablet #2 8/1/23Resident 3 5638821 Oxycodone 5 mg tablet #10 8/25/23Resident 4 5520097 Hydrocodone (narcotic pain reliever)/APAP 5/325 mg tab #32 5/27/23Resident 5 5437319 Hydrocodone/APAP 10/325 mg tab #38 5/9/23Resident 6 5604363 Hydrocodone/APAP 10/325 mg tab #17 6/16/23Resident 7 5709661 Hydrocodone/APAP 10/325 mg tab #12 7/13/23Resident 8 5479374 Oxycodone 5 mg tablet #36 5/18/23They stated the facility could not locate the corresponding Shipping Manifests. During a concurrent interview and record review, on 4/17/26 at 10:30 a.m., DON, ADON and MRD identified the resident's CDRs listed below. They (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	compared the CDR medication removal against the MAR. They acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below. Resident 6 5604363 Hydrocodone/APAP 10/325 mg tab #17 6/16/236/23/23 23407/4/23 1110Resident 7 5709661 Hydrocodone/APAP 10/325 mg tab #12 7/13/237/14/23 21007/15/23 21007/16/23 0657, 1101Resident 1 5914390 Oxycodone/APAP 5/325 mg tab #30 9/4/239/10/23 0601, 20009/12/23 05079/17/23 3 removed from CDR, 2 documented on MARResident 8 5479374 Oxycodone 5 mg tablet #36 5/18/235/22/23 2300Resident 2 5781740 Oxycodone 5 mg tablet #2 8/1/238/2/23 1110, 11108/3/23 1400, 1400Continuing the interview and record review, on 4/17/26 at 10:30 a.m., DON, ADON and MRD, were requested to provide the Pharmacist inspection reports for 5/1/23-8/31/23. They identified the Executive Summary of Consultant Pharmacist's Medication Regimen Review, for dates 6/1-6/30/23, 7/1-7/31/23 and 8/1-8/31/23. DON and ADON inspected the reports and stated there was no documentation of issues of incomplete or inaccurate scheduled medication records. During a concurrent interview and record review, on 4/17/26 at 10:59 am, DON, ADON and MRD identified the policy for Controlled Substances (Revision Date November 2022). They reviewed the policy and acknowledged it required the documentation (Shipping Manifests, CDRs and MARs) to be complete (all documents available) and accurate (monitored and reconciled). During a concurrent interview and record review, on 4/17/26 at 11:07 a.m., DON, ADON and MRD, identified the policy for Pharmacy Services-Role of the Consultant Pharmacist (Revision Date April 2019). They reviewed the policy and stated that it was the facility's expectation that issues with scheduled medications should have been evaluated and identified.An administrative record review, of the Executive Summary of Consultant Pharmacist's Medication Regimen Review, for dates 6/1-6/30/23, 7/1-7/31/23 and 8/1-8/31/23, showed random narcotic audits were completed in 6/2023 and 8/2023. There were no documented findings from the narcotic audits.An administrative record review, of the policy for Controlled Substances (Revision Date November 2022) showed, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled (complete and accurate) to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records.An administrative record review, of the Policy for Pharmacy Services-Role of the Consultant Pharmacist (Revision Date April 2019) showed, Policy Interpretation and Implementation, 3. The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to:, a. develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on observation, interview and record review, the facility failed to ensure the administrator who supervised and directed the facility operations was licensed according to state regulation when the unlicensed Operations Manager (OM) had the role of administrator for more than two years and five months.This failure resulted residents and staff being supervised and directed by unqualified administrative leadership.During an observation on 7/23/25 at 11:19 a.m. a facility post board near the nurses station was inspected. The post board had a nursing home administrator (NHA) license holder (NHAH) which indicated OM was not the licensed administrator of the facility. The post board also had a letter to residents and families which was signed Sincerely, ADMINISTRATOR [OM]'s signature. NHAH was not at the facility.During a record review of two facility financial reports submitted to the state agency titled, Long Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, dated 12/31/23 and 12/31/24, the report listed OM as the administrator. The two reports did not list the facility's Reported Administrator (RA) in 2023 or 2024 in any part of the document.A review of state agency database indicated RA was reported to the state agency as the facility's administrator from 3/2023 to 5/2025.A review of state nursing home administrator license database, accessed on 7/23/25, indicated OM did not have a NHA license.During a record review of the facility staff sign in sheet titled, [Facility] Screening Log, dated 7/23/25, the sheet indicated a printed assignment of OM as the administrator. The sheet did not indicate NHAH was part of the staff sign in sheet.During a concurrent observation, interview and record review on 7/23/25 at 1:15 p.m. with OM outside of the Administrator office, OM's business card was reviewed. OM introduced himself as the administrator. Surveyor received a business card with OM's name and the title Administrator under OM's name. OM stated the office which said Administrator was his office.A review of Resident 9's admission record indicated Resident 9 was admitted for heart failure, kidney disease and respiratory failure.During a record review of Resident 9's minimum data set (MDS, an assessment tool to guide resident care), dated 4/4/25, the MDS indicated Resident 9 had Brief Interview for Mental Status score of 15 (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.)A record review of Resident 9's nursing note titled, Nursing Weekly Summary, dated 7/21/25, was reviewed, the nursing note indicated Resident 9 did not have any memory deficits and was alert and oriented.During an interview on 7/23/25 at 1:53 p.m. with Resident 9, Resident 9 stated they were the resident council president. Resident 9 stated he spoke with OM frequently and stated OM was the administrator of the facility.During an interview on 7/23/25 at 2:05 p.m. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON and ADON both stated OM was the administrator for almost three years since the facility's operating organization purchased the facility.During a concurrent interview and record review on 7/23/25 at 2:35 p.m. with Director of Social Work (DSW), six resident grievance logs, dated 1/4/25 through 5/15/25, were reviewed. DSW stated the grievance logs were reviewed and signed by the administrator. DSW stated OM's signature was on the administrator line for all six logs.During an interview on 7/23/25 at 3:25 p.m. with OM, OM stated they were responsible for following up on grievances and signing off as completed. OM stated they started as the administrator in 3/2023.During an interview on 7/23/25 at 3:55 p.m. with the DON, the DON stated OM was the administrator at quality assurance and performance improvement (QAPI) meetings.During a concurrent interview and record review at 7/23/25 at 4:08 p.m. with OM, the facility monthly QAPI documents titled, QAA Committee Agenda/Minutes/Sign in Sheet, dated from 1/2025 to 6/2025 were reviewed. OM stated they worked with other department leaders to make and execute action plans. The QAPI documents indicated OM had signed in as the administrator for all six months.During concurrent interview and record review on 7/23/25 at 4:10 p.m. with OM, the facility's job description for operations manager and administrator titled, Operations Manager, dated 2/2024, and Administrator, (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dated 12/2018, were reviewed. OM stated he was not a licensed nursing home administrator and had not taken recent steps to have the license completed. OM stated NHAH was the administrator of the building. OM stated the NHAH was also the Regional Operations Manager of the facility's operating corporation since March 2025 and OM reported to NHAH. A review of both job descriptions indicated both operations manager and administrator reported to the Regional Director of Operations. Both job descriptions indicated an operations manager and administrator needed licenses.must maintain licensing credentials for an Administrator.During a phone interview on 5/11/26 at 2:00 p.m. with the NHAH, NHAH stated they were the reported administrator for the facility from 4/2025 to 8/2025, and they were the facility's operation corporation's regional operations manager. NHAH stated Reported Administrator (RA) was the facility administrator prior to them. NHAH stated the operations manager can perform duties delegated to them by the administrator but should not be calling themselves the administrator. NHAH stated they were unaware of OM acting as the facility administrator.During a review of facility policy and procedure (P&P) titled, Grievances/Complaints, Filing, dated 04/2017, the P&P indicated the administrator has delegated responsibility of grievance and/or complaint investigation to the Social Service.the grievance officer will.submit a written report of the findings to the administrator within five (5) working days.the administrator will review the findings.During a review of state health and safety code titled, California Code, Health and Safety Code 1416.6 (a), the code indicated it shall be a misdemeanor for any person to act or serve in the capacity of a nursing home administrator, unless he or she is the hold of an active nursing home administrator's license.During a review of state regulation titled, Title 22, Chapter 3. Skilled Nursing Facilities, 72007 Administrator, the regulation defined an administrator as a person licensed as a nursing home administrator by the California Board of Examiners of Nursing Home Administrators.