

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3780 Massachusetts Avenue LA Mesa, CA 91941	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement individualized, person-centered discharge care plans that reflected each individualized, person-centered discharge for three of five sampled residents (Resident 1, 3 and 4) with the same generic and identical goals and interventions for each resident. These deficient practices placed three residents (Resident 1, 4 and 5) at risk for unmet healthcare needs, poor coordination of care, ineffective discharge planning, interruption in continuity of care, and avoidable health complications after discharge. Cross Reference F627 and F628. Findings: 1. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body)/Hemiparesis weakness on one side of the body) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/2/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 7 points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 a record review was conducted on Resident 1's discharge care plan that indicated, .Discharge/Transfer Planning Preference: ☐ Resident ☐ Resident's Responsible Party/Family Members indicates preference to discharge to: [BLANK] Date Initiated: 06/02/2026 Goals: Current level of care is appropriate considering current physical/social/emotional status Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Improve independence with ADLs and/or mobility to allow for safe discharge to (enter). Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Medical condition(s) will improve to extent possible to allow for safe discharge to (enter). Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Pain will be managed to allow for safe discharge to (enter). Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Risk for (specify: Isolation, decreased appetite, increased mood problems, signs, and symptoms of anxiety) will be minimized as the resident becomes comfortable with current environment while discharge planning takes place. Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Will be comfortable in their environment. Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Will be discharged to ☐ appropriate placement ☐ (enter) which will meet individualized health objectives. Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: 09/02/2026 Will meet resident/resident representative discharge goal/plan of ☐ return to community ☐ remain in this facility ☐ transfer to another long-term care facility ☐ Hospice care services ☐ Respite care services ☐ Other (specify). Date Initiated: 06/02/2026 Revision on: 06/11/2026 Target Date: (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/02/2026 Coordinate DME, pharmacy, home health, and/or in-home support services. Date Initiated: 06/02/2026 Social services to document changes to discharge goal per resident/resident representative preference as indicated. Date Initiated: 06/02/2026 Social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. Date Initiated: 06/02/2026. On 7/22/26 at 10:47 A.M., an interview and record review was conducted with the Social Services Assistant (SSA). The SSA read out loud (Resident 1, 4, and 5) discharge care plan. The SSA stated I should have updated the care plans for all three residents (Resident 1, 4, and 5). The SSA stated the discharge care plans was not updated and for all three discharges. The SSA stated It is important to update the care plan to identify their needs upon discharge and should be personalized that works for the resident for safety and for continuum of care otherwise they can decline overall and it would not be a successful discharge. The SSA stated the discharge care plans for all three residents were cut and paste. On 7/22/26 11:34 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated all three residents (Resident 1, 4, and 5) had the same discharge care plans and generic. LN 1 stated it's important for a personalized discharge care plan so that we are addressing the health and safety needs of the residents to prevent re-admissions and health decline. It is important. On 7/22/26 12:14 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON read out loud (Resident 1, 4, and 5's) discharge care plan. The ADON stated that all three residents (Resident 1, 4, and 5's) discharge care plan was basically all the same and generic. It is not personalized and it is a copy and paste for the discharge care plans. The ADON stated we need to have personalized discharge care plan as a means to communicate with each other as well as have the resident/family involved that is personalized to prevent health declines, safety and re-admissions when they discharge. That way it makes sure that we meet all their discharge needs. Discharge care plans are needed to ensure safe and orderly discharges to prevent further health decline and safety. On 7/22/26 at 12:29 P.M., an interview and record review was conducted with the Social Service Director (SSD). The SSD read out loud (Resident 1, 4, and 5's) discharge care plan. The SSD stated all three residents (Resident 1, 4, and 5's) discharge care plans was not personalized and generic because we have not been revising them. The SSD stated discharge planning takes time to plan so that nothing gets missed and addressed appropriately so supplies, medications, MD/Social services concerns are discussed plus we need to order DME's we need to know ahead of time what the role is to what we need to do to have a proper safe transition to their discharge location to prevent hospitalizations, and complications when they leave. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-centered dated March 2022, indicated .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MOS assessment(Admission, Annual or Significant Change in Status), and no more than 21 days after admission 2. A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included history of Diabetes Mellitus Type II (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).A record review of Resident 4's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/3/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 12 points out of 15 possible points which indicated Resident 4 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 a record review was conducted on Resident 4's discharge care plan indicated, .Discharge/Transfer Planning Preference: ☐ Resident ☐ Resident's Responsible Party/Family Members indicates preference to discharge to: [BLANK] Date Initiated: 06/01/2026 Revision on: 07/05/2026 Cancelled (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date: 07/05/2026 Goals: Current level of care is appropriate considering current physical/social/emotional status Date Initiated: 06/02/2026 Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Improve independence with ADLs and/or mobility to allow for safe discharge to (enter). Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Medical condition(s) will improve to extent possible to allow for safe discharge to (enter). Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Pain will be managed to allow for safe discharge to (enter). Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Risk for (specify: Isolation, decreased appetite, increased mood problems, signs, and symptoms of anxiety) will be minimized as the resident becomes comfortable with current environment while discharge planning takes place Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Will be comfortable in their environment Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Will be discharged to [] appropriate placement [] (enter) which will meet individualized health objectives Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Will meet resident/resident representative discharge goal/plan of [] return to community [] remain in this facility [] transfer to another long-term care facility [] Hospice care services [] Respite care services [] Other (specify). Date Initiated: 06/01/2026 Revision on: 07/05/2026 Target Date: 08/28/2026 Cancelled Date: 07/05/2026 Coordinate DME, pharmacy, home health, and/or in-home support services. Date Initiated: 06/01/2026 Revision on: 07/05/2026 Cancelled Date: 07/05/2026 Social services to document changes to discharge goal per resident/resident representative preference as indicated. Date Initiated: 06/01/2026 Revision on: 07/05/2026 Cancelled Date: 07/05/2026 Social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. Date Initiated: 06/01/2026 Revision on: 07/05/2026 Cancelled Date: 07/05/2026 On 7/22/26 at 10:47 A.M., an interview and record review was conducted with the Social Services Assistant (SSA). The SSA read out loud (Resident 1, 4, and 5) discharge care plan. The SSA stated I should have updated the care plans for all three residents (Resident 1, 4, and 5). The SSA stated the discharge care plans was not updated and for all three discharges. The SSA stated It is important to update the care plan to identify their needs upon discharge and should be personalized that works for the resident for safety and for continuum of care otherwise they can decline overall and it would not be a successful discharge. The SSA stated the discharge care plans for all three residents were cut and paste. On 7/22/26 11:34 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated all three residents (Resident 1, 4, and 5) had the same discharge care plans and generic. LN 1 stated it's important for a personalized discharge care plan so that we are addressing the health and safety needs of the residents to prevent re-admissions and health decline. It is important. On 7/22/26 12:14 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON read out loud (Resident 1, 4, and 5's) discharge care plan. The ADON stated that all three residents (Resident 1, 4, and 5's) discharge care plan was basically all the same and generic. It is not personalized and it is a copy and paste for the discharge care plans. The ADON stated we need to have personalized discharge care plan as a means to communicate with each other as well as have the resident/family involved that is personalized to prevent health declines, safety and re-admissions when they discharge. That way it makes sure that we meet all their discharge needs. Discharge care plans are needed to ensure safe and orderly discharges to prevent further health decline and safety. On 7/22/26 at 12:29 P.M., an interview and record review was conducted with the Social Service (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director (SSD). The SSD read out loud (Resident 1, 4, and 5's) discharge care plan. The SSD stated all three residents (Resident 1, 4, and 5's) discharge care plans was not personalized and generic because we have not been revising them. The SSD stated discharge planning takes time to plan so that nothing gets missed and addressed appropriately so supplies, medications, MD/Social services concerns are discussed plus we need to order DME's we need to know ahead of time what the role is to what we need to do to have a proper safe transition to their discharge location to prevent hospitalizations, and complications when they leave. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-centered dated March 2022, indicated .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MOS assessment(Admission, Annual or Significant Change in Status), and no more than 21 days after admission 3. A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included history of Wedge (front of back bone) Compression Fracture (a squashed spine bone where the front part collapses into a wedge or doorstop shape while the back stays the same height) of the fourth lumbar vertebrae (lower back bone).A record review of Resident 5's minimum data set (MDS - a federally mandated resident assessment tool) dated 3/26/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 11 points out of 15 possible points which indicated Resident 5 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 a record review was conducted on Resident 5's discharge care plan indicated, .Discharge/Transfer Planning Preference: ☐ Resident ☐ Resident's Responsible Party/Family Members indicates preference to discharge to: [BLANK] Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Goals: Current level of care is appropriate considering current physical/social/emotional status Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Improve independence with ADLs and/or mobility to allow for safe discharge to (enter). Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Medical condition(s) will improve to extent possible to allow for safe discharge to (enter). Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Pain will be managed to allow for safe discharge to (enter). Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Risk for (specify: Isolation, decreased appetite, increased mood problems, signs, and symptoms of anxiety) will be minimized as the resident becomes comfortable with current environment while discharge planning takes place Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Will be comfortable in their environment 03/26/2026 Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Will be discharged to ☐ appropriate placement ☐ (enter) which will meet individualized health objectives Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Will meet resident/resident representative discharge goal/plan of ☐ return to community ☐ remain in this facility ☐ transfer to another long-term care facility ☐ Hospice care services ☐ Respite care services ☐ Other (specify). Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Coordinate DME, pharmacy, home health, and/or in-home support services. Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Social services to document changes to discharge goal per resident/resident representative preference as indicated. Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026 Social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. Date Initiated: 03/22/2026 Revision on: 06/02/2026 Cancelled Date: 06/02/2026. 7/22/26 10:47 AM SSA ([NAME], [NAME] I/RR) Admit 5/25/26 DC 7/3/26 Dx DM type II w/o complications MDS 7/3/26 BIMS 12 Resident dc'd w/ caregiver he went home with (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PT/OT/RN DME. Discharge careplan in place but not locations updated. Date initiated 6/1/26. We have a NOMNOC on 6/29/26 I should have updated the care plan (read out loud at the same time with the undersigned for [NAME], [NAME] and [NAME] it was a cut/paste) The discharge careplan was not updated and personalized (all three of them [NAME], [NAME] and [NAME]). It is important to update the care plan to identify their needs upon discharge and should be personalized that works for the resident for safety and for continuum of care otherwise they can decline overall and it would not be a successful discharge. 7/22/26 10:50 AM SSA ([NAME], [NAME] I/RR) DxDischarge CP initiated 3/19/26. The care plan was not revised or personalized (read out loud at the same time with the undersigned for [NAME], [NAME] and [NAME] it was a cut/paste). She was with Tri-care. It is important to update the care plan to identify their needs upon discharge and should be personalized that works for the resident for safety and for continuum of care otherwise they can decline overall and it would not be a successful discharge. 7/22/26 11:34 AM [NAME] [NAME] RN ([NAME]-I/RR) Yes, she had a Gtube. On the 14th the 2 daughters came and were educated by Erish [NAME] LVN. He teach them about TF using the Kangaroo pump, syringe, and everything how to do the machine and they were understanding of instructions by return demonstration. One of the daughters was even more interested than the other daughter. The discharge care plan we didn't personalize to put the teaching that we did. It's the same as the other care plans ([NAME], [NAME] and [NAME]).Grivette there is no dc care plan. It should be initiated within 48H and revised. It's important for a personalized discharge care plan so that we are addressing the health and safety needs of the residents to prevent re-admissions and health decline. It is important. Erish is not here but we can call him. 7/22/26 12:14 PM ADON (I/RR)- [NAME], [NAME] and [NAME] (Read care plans at the same time with the undersigned and it was copy and paste no personalization). Well, I guess I can't talk my way out of that. It's basically all the same and generic. It is not personalized and it is a copy and paste for the discharge care plans. For Grivett, there is no discharge care plan and there should be one because discharge planning starts on admission. We need to have personalized discharge care plan as a means to communicate with each other as well as have the resident/family involved that is personalized to prevent health declines, safety and re-admissions when they discharge. That way it makes sure that we meet all their discharge needs. Discharge care plans are needed to ensure safe and orderly discharges to prevent further health decline and safety. 7/22/26 12:29 PM [NAME] SSD (I/RR) I will tell you I'm still having a lot of fixing up to do with our department. I've been for 6 months and I realize that our discharge care plans are not personalized and/or revised on timely. The IDT meeting have not been scheduled since I got here. I usually do progress notes and options on what they decided. - [NAME], [NAME] and [NAME] (Read care plans at the same time with the undersigned and it was copy and paste no personalization). The discharge care plans are not personalized and generic because we have not been revising them. Grivett- there is no discharge care plan at all and it should be initiated within 48 hours and revised. I know it will take time to fix our department. DC planning takes time to plan so that nothing gets missed and addressed appropriately so supplies, medications, MD/Social services concerns are discussed plus we need t o order DME's we need to know ahead of time what the role is to what we need to do to have a proper safe transition to their discharge location to prevent hospitalizations, and complications when they leave. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-centered dated March 2022, indicated .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MOS assessment(Admission, Annual or Significant Change in Status), and no more than 21 days after admission		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prepare a safe and coordinated discharge for one of five sampled residents (Resident 1) by not providing necessary equipment for a continuous tube feeding(TF-way to give liquid food, water, and medicine directly into the stomach or small intestine through a soft plastic tube when a person cannot safely chew or swallow) order and/or necessary teaching to administer a bolus (a way to give liquid food or formula through a feeding tube like a meal, using a large syringe several times a day) feeding as revised due to no feeding pump (machine used to deliver tube feedings).These deficient practices placed Resident 1 at risk for missed needed nutrition, delayed feeding, poor nutritional status, dehydration, re-hospitalization, and complications related to not receiving prescribed TFs after discharge.Cross Reference F628 and F656. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body)/Hemiparesis weakness on one side of the body) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/2/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 7 points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 at 8A.M., an interview with Resident 1's Family Member (FM) was conducted via telephone. FM stated that the facility had discharged her mother (Resident 1) without a Kangaroo (a portable medical machine used to feed liquid nutrition and water directly into a person's stomach or small intestine through a feeding tube) pump that was necessary to give Resident 1 her nutritional needs via tube feeding. FM stated she gave the Social Services Assistant (SSA) the number to call for the home health (HH) company to include needing an order for the TF and to notify them that they did not get a Kangaroo pump and it needed to be ordered prior to the day of discharge. FM stated her mother (Resident 1) did not receive her TF the following day at home after discharge and went without nutrition when it was supposed to be hung in the morning (8AM-9AM). FM stated that her sister went back to the facility the next day (July 17, 2026) which they gave her 3-4 feeding solutions with tubing without no pump and an updated order for a bolus instead of continuous feeding via the Kangaroo pump. FM stated she and her sister did not get any instructions and/or special training to administer a bolus feed. FM stated she thought the facility was going to give her sister a Kangaroo pump but instead gave her protein shakes and TF supplies without the Kangaroo pump, however Resident 1 did not want to eat or drink anything and went without her nutritional intake. FM stated about noon that day (July 17, 2026) they received a fax from the facility with the order for the bolus feed to be given every four hours. FM stated they (HH, FM and FM sister) requested for other documents (no H&P, no face sheet, no discharge care plan, no advanced directive (AD-a legal document indicating resident preference on end-of-life treatment decisions) , no progress notes, no discharge summary, & no special instructions or precautions for ongoing care for TF or wounds. FM stated she nor her sister was taught how to administer TF via bolus and only was taught using the Kangaroo pump upon discharge. On 7/22/26 at 8:22 A.M., an interview with the HH Registered Nurse (HHRN) conducted via telephone (HHRN was at Resident 1's residence at the time of the interview). The HHRN stated the facility discharged Resident 1 without ensuring a safe transition of care. The HHRN stated the facility faxed only a HH physical (PT) and (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occupational (OT) order on the afternoon of the discharge (7/16/26). The HHRN stated the following day (7/17/26), she only received an order for the TF bolus that was changed from the original discharge orders for continuous feeding. The HHRN stated she did not receive Resident 1's History and Physical (H&P), face sheet (FS), discharge summary, discharge care plan, AD, progress notes, or instructions for ongoing TF and wound management. The HHRN stated Resident 1 arrived home without the required feeding pump, the family had not been instructed on how to administer the prescribed bolus TF, and Resident 1 was unable to receive the ordered nutrition because the necessary equipment (Kangaroo pump) and complete discharge information had not been provided. On 7/22/26 at 9:48 A.M., an interview and record review was conducted with the Social Services Assistant (SSA). The SSA stated she initiated Resident 1's discharge care plan on 6/2/26 but failed to update and individualize the care plan before discharge to reflect Resident 1's discharge destination, caregiver support, TF needs, required durable medical equipment (DME), and ongoing services. The SSA stated the discharge care plan was not personalized and should have been revised to identify Resident 1's return home with her daughter and son, Resident 1's prescribed TF regimen, caregiver education needs, and equipment necessary for a safe discharge. The SSA stated the facility failed to order the required Kangaroo Pump before discharge, despite knowing Resident 1's nutritional needs. The SSA admitted she forgot to order the feeding pump and left TF education to nursing without confirming with Resident 1's family had been instructed before discharge. The SSA stated Resident 1's daughter later reported that Resident 1's feeding was delayed because the feeding pump had not been provided. The SSA further stated that the interdisciplinary team (IDT- a group of different experts, such as doctors, therapists, nurses and social workers, who work closely together) was responsible for identifying discharge needs, coordinating with nursing, therapy, HH, Resident 1, and family, arranging caregiver education, and ensuring all services and supplies were in place before discharge. The SSA stated these processes were not completed for Resident 1. The SSA also stated that the facility did not routinely conduct formal IDT discharge planning meetings and relied on informal communication among staff/ The SSA stated HH should have received Resident 1's FS, physician orders, H&P, discharge summary, progress notes, rehabilitation notes, and other documents as requested for continuum of care however, she acknowledged she only faxed HH order on 7/15/26 and the revised bolus TF order on 7/16/26 after Resident 1 had already discharged home. The SSA stated she had no documentation identifying what records were transmitted and only retained fax confirmation reports showing that only 2 pages were sent on each date. On 7/22/26 a record review was conducted on Resident 1's clinical chart with diet orders that included an order for TF started 6/3/26 .Enteral [into the stomach] Feed Order every shift TUBE FEEDING FORMULA: Fibersource HN [TF brand] @ [at] 60 [milliliters]/HR [hour] x 20 HRS, TV [total volume] 1200 ML (1440 kcal [kilocalories], 65 g [gram] pro [protein], 972 ml free water). and 6/23/26 .Enteral Feed Order every shift TUBE FEEDING FORMULA: Fibersource HN@ 60 ML/HR x 15 HRS, TV 900 ML (1080 kcal, 49g pro, 729 ml free water). On 7/22/26 a record review was conducted on Resident 1's clinical chart that included an order started on 7/17/26 (day after discharge) that indicated, .Bolus Feeding: Fiber source HN [TF Brand] 225 ml via g-tube [gastrostomy tube-is a soft, flexible tube placed through a small hole in the belly directly into the stomach to deliver liquid food, fluids, and medicines]. On 7/22/26 a record review was conducted on Resident 1's clinical chart. There was no records to indicate that FS, POS, progress notes, discharge summaries, special instructions, AD, rehab notes and H&P notes for continuum of care was sent to the HH. On 7/22/26 at 11:18 A.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated the facility discharged Resident 1 with orders for continuous TF and failed to obtain and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3780 Massachusetts Avenue LA Mesa, CA 91941	
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicate the revised bolus TF until after Resident 1 had already returned home. The ADON stated the facility did not order the required Kangaroo pump before discharge and acknowledged Resident 1's daughter contacted the facility upset because Resident 1 missed her scheduled morning TF due to the lack of equipment. The ADON stated Resident 1 had poor oral intake during her stay and relied on TF to meet her nutritional needs. The ADON stated that delaying TF placed Resident 1 at risk for continued nutritional decline, weight loss, and worsening health status. On 7/22/26 at 11:34 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 had a G-tube and confirmed Resident 1's two daughters received instructions on administering TF using the Kangaroo pump, syringe (a device used to inject fluids into or withdraw them from the body), and return demonstration before discharge but not for the TF bolus feed. LN 1 acknowledged the discharge care plan was not updated or individualized to reflect Resident 1's TF regimen, caregiver education, equipment needs, or specific discharge instructions and was essentially the same as the other sampled residents' (Resident 4 and Resident 5) discharge care plans. LN 1 stated an individualized discharge care plan is necessary to communicate Resident 1's specific health and safety needs, guide caregivers after discharge, promote continuity of care, and reduce the risk of re-hospitalization and further health decline. On 7/22/26 at 11:41 A.M., an interview was conducted with LN 2 via telephone. LN 2 stated he provided Resident 1's daughters with education on G-tube care including recognizing signs and symptoms of infection, verifying tube placement before initiating feedings, checking gastric (stomach) residuals (left over TF fluid), operating the Kangaroo pump for continuous TF, and notifying physician when residual volumes exceed 100 ml. LN 2 stated he did not teach Resident 1's daughters how to do a bolus TF because that was the active order at the time of discharge (7/16/26) for continuous TF and not a bolus. LN 2 acknowledged that if a bolus TF order had been received prior to discharge, he would have instructed Resident 1's daughters on the revised feeding method. LN 2 stated missing prescribed TF could place Resident 1, who had poor oral intake and depended on TF for nutrition, at risk for weight loss, nutritional decline, and worsening health status. On 7/22/26 12:14 PM ADON an interview and record review was conducted with the ADON. The ADON reviewed Resident 1's discharge care plan (along with Resident 4 and Resident 5) and acknowledged the discharge care plans were generic, contained copied information, and were not individualized to reflect each resident's (Resident 1, Resident 4 and Resident 5) specific discharge needs. The ADON stated discharge planning begins on admission and discharge care plan should be updated throughout a resident's (all facility residents) stay to communicate the resident's (all facility residents) stay to communicate resident's (all facility residents) individualized needs to the IDT, all residents, family, caregivers, and post discharge providers. The ADON stated an individualized discharge care plan is necessary to coordinate services, identify required equipment, provide caregiver education, promote continuity of care, reduce the risk of rehospitalization, and prevent further health decline. The ADON stated that Resident 1's revised order for the bolus TF was not discussed or provided education to Resident 1's daughters upon discharge. The ADON stated Resident 1 left the facility without a Kangaroo pump and had to miss her feeding because of the lack of equipment to administer the discharge TF instructions. The ADON stated that Resident 1's discharge process did not ensure Resident 1's discharge plan, physician orders, caregiver education, and necessary equipment were coordinated and implemented before discharge. On 7/22/26 at 12:29 P.M., an interview and record review was conducted with the Social Services Director (SSD). The SSD stated the facility's discharge care plans were not consistently revised or individualized to reflect residents' (all facility residents) specific discharge needs. The SSD stated the IDT had not conducted routine discharge planning meeting since her employment began 6 months earlier and admitted that (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge care plans for (Resident 1, Resident 4 and Resident 5) contained generic, copied information rather than resident-specific discharge interventions. The SSD stated effective discharge planning requires advance coordination among nursing, therapy, social services, physicians, residents (all facility residents) and caregivers to identify equipment needs, arrange DME, coordinate medications and supplies, address psychosocial concerns, and ensure a safe transition to the discharge location. The SSD stated these processes were intended to prevent complications, avoid rehospitalization, and promote continuity of care. On 7/22/26 at 12:36 P.M., an interview and record review was conducted with the Social Services Director (SSD) specifically for Resident 1. The SSD stated the facility knew before discharge that Resident 1 required TF's and HH services; however, the facility failed to arrange the required Kangaroo pump before discharge. The SSD stated it was the facility's responsibility to coordinate with the HH agency for obtaining the feeding pump (Kangaroo pump) and admitted the facility should have ordered the equipment before Resident 1 returned home. The SSD stated the facility mistakenly assumed Resident 1's daughter or the HH agency would arrange the feeding pump, resulting in Resident 1 missing prescribed TF after discharge because the equipment was not ordered and unavailable to function Resident 1's continuous TF orders. The SSD further stated the facility cannot assume another provider will coordinate essential discharge equipment or services and stated that failure to provide the required feeding pump and coordinate discharge services placed Resident 1 at risk for interrupted nutrition, weight loss, worsening health status, and re-hospitalization. On 7/29/26 at 10:25 A.M., an interview was conducted via telephone with Resident 1's FM. FM stated the HH agency had still not received Resident 1's clinical records from the facility needed to provided ongoing care. FM stated the HH agency planned to contact the facility directly to request for missing records necessary for continuity of care. RM stated the delay in transmitting Resident ?s clinical information continued after discharged and interfered with coordination of Resident 1's post-discharge services. A review of the facility's policy and procedure titled, Discharge Summary and Plan dated March 2025, indicated The discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and the representative to develop interventions to meet the resident's discharge goals and needs that must be addressed before the resident can be safely discharged (e.g., caregiver support and education, rehabilitation, etc.) . Discharge planning identifies the discharge destination, and ensures that it meets the resident's health and safety needs, as well as preferences.c. needed medical and non-medical services (including medical equipment).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate a safe and effective discharge for one for five sampled residents (Resident 1) by ensuring caregivers received education on prescribed tube feeding (TF-way to give liquid food, water, and medicine directly into the stomach or small intestine through a soft plastic tube when a person cannot safely chew or swallow), providing necessary equipment for TF feeding pump (machine used to deliver tube feedings) before discharge, communicating updated physician orders to the receiving Home Health Agency (HHA), and transferring complete clinical information necessary for continuity of care. These deficient practices placed Resident 1 at risk for interruption of prescribed TF feedings, inadequate nutrition, weight loss, dehydration, worsening health status, delayed continuity of care, and avoidable rehospitalization. Cross Reference F627 and F656. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body)/Hemiparesis weakness on one side of the body) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 6/2/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 7 points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 at 8A.M., an interview with Resident 1's Family Member (FM) was conducted via telephone. FM stated that the facility had discharged her mother (Resident 1) without a Kangaroo (a portable medical machine used to feed liquid nutrition and water directly into a person's stomach or small intestine through a feeding tube) pump that was necessary to give Resident 1 her nutritional needs via tube feeding. FM stated she gave the Social Services Assistant (SSA) the number to call for the home health (HH) company to include needing an order for the TF and to notify them that they did not get a Kangaroo pump and it needed to be ordered prior to the day of discharge. FM stated her mother (Resident 1) did not receive her TF the following day at home after discharge and went without nutrition when it was supposed to be hung in the morning (8AM-9AM). FM stated that her sister went back to the facility the next day (July 17, 2026) which they gave her 3-4 feeding solutions with tubing without no pump and an updated order for a bolus (a way to give liquid food or formula through a feeding tube like a meal, using a large syringe several times a day) instead of continuous feeding via the Kangaroo pump. FM stated she and her sister did not get any instructions and/or special training to administer a bolus feed. FM stated she thought the facility was going to give her sister a Kangaroo pump but instead gave her protein shakes and TF supplies without the Kangaroo pump, however Resident 1 did not want to eat or drink anything and went without her nutritional intake. FM stated about noon that day (July 17, 2026) they received a fax from the facility with the order for the bolus feed to be given every four hours. FM stated they (HH, FM and FM sister) requested for other documents (no H&P, no face sheet, no discharge care plan, no advanced directive (AD-a legal document indicating resident preference on end-of-life treatment decisions) , no progress notes, no discharge summary, & no special instructions or precautions for ongoing care for TF or wounds. FM stated she nor her sister was taught how to administer TF via bolus and only was taught using the Kangaroo pump upon discharge. On 7/22/26 at 8:22 A.M., an interview with the HH Registered Nurse (HHRN) conducted via telephone (HHRN was at Resident 1's (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residence at the time of the interview). The HHRN stated the facility discharged Resident 1 without ensuring a safe transition of care. The HHRN stated the facility faxed only a HH physical (PT) and occupational (OT) order on the afternoon of the discharge (7/16/26). The HHRN stated the following day (7/17/26), she only received an order for the TF bolus that was changed from the original discharge orders for continuous feeding. The HHRN stated she did not receive Resident 1's History and Physical (H&P), face sheet (FS), discharge summary, discharge care plan, AD, progress notes, or instructions for ongoing TF and wound management. The HHRN stated Resident 1 arrived home without the required feeding pump, the family had not been instructed on how to administer the prescribed bolus TF, and Resident 1 was unable to receive the ordered nutrition because the necessary equipment (Kangaroo pump) and complete discharge information had not been provided. On 7/22/26 at 9:48 A.M., an interview and record review was conducted with the SSA. The SSA stated she initiated Resident 1's discharge care plan on 6/2/26 but failed to update and individualize the care plan before discharge to reflect Resident 1's discharge destination, caregiver support, TF needs, required durable medical equipment (DME), and ongoing services. The SSA stated the discharge care plan was not personalized and should have been revised to identify Resident 1's return home with her daughter and son, Resident 1's prescribed TF regimen, caregiver education needs, and equipment necessary for a safe discharge. The SSA stated the facility failed to order the required Kangaroo Pump before discharge, despite knowing Resident 1's nutritional needs. The SSA admitted she forgot to order the feeding pump and left TF education to nursing without confirming with Resident 1's family had been instructed before discharge. The SSA stated Resident 1's daughter later reported that Resident 1's feeding was delayed because the feeding pump had not been provided. The SSA further stated that the interdisciplinary team (IDT- a group of different experts, such as doctors, therapists, nurses and social workers, who work closely together) was responsible for identifying discharge needs, coordinating with nursing, therapy, HH, Resident 1, and family, arranging caregiver education, and ensuring all services and supplies were in place before discharge. The SSA stated these processes were not completed for Resident 1. The SSA also stated that the facility did not routinely conduct formal IDT discharge planning meetings and relied on informal communication among staff/ The SSA stated HH should have received Resident 1's FS, physician orders, H&P, discharge summary, progress notes, rehabilitation notes, and other documents as requested for continuum of care however, she acknowledged she only faxed HH order on 7/15/26 and the revised bolus TF order on 7/16/26 after Resident 1 had already discharged home. The SSA stated she had no documentation identifying what records were transmitted and only retained fax confirmation reports showing that only 2 pages were sent on each date. On 7/22/26 a record review was conducted on Resident 1's clinical chart with diet orders that included an order for TF started 6/3/26 .Enteral [into the stomach] Feed Order every shift TUBE FEEDING FORMULA: Fibersource HN [TF brand] @ [at] 60 [milliliters]/HR [hour] x 20 HRS, TV [total volume] 1200 ML (1440 kcal [kilocalories], 65 g [gram] pro [protein], 972 ml free water). and 6/23/26 .Enteral Feed Order every shift TUBE FEEDING FORMULA: Fibersource HN@ 60 ML/HR x 15 HRS, TV 900 ML (1080 kcal, 49g pro, 729 ml free water). On 7/22/26 a record review was conducted on Resident 1's clinical chart that included an order started on 7/17/26 (day after discharge) that indicated, .Bolus Feeding: Fiber source HN [TF Brand] 225 ml via g-tube [gastrostomy tube-is a soft, flexible tube placed through a small hole in the belly directly into the stomach to deliver liquid food, fluids, and medicines]. On 7/22/26 a record review was conducted on Resident 1's clinical chart. There was no records to indicate that FS, POS, progress notes, discharge summaries, special instructions, AD, rehab notes and H&P notes for continuum of care was sent to the HH. On 7/22/26 at 11:18 A.M., an interview and record review was (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the Assistant Director of Nursing (ADON). The ADON stated the facility discharged Resident 1 with orders for continuous TF and failed to obtain and communicate the revised bolus TF until after Resident 1 had already returned home. The ADON stated the facility did not order the required Kangaroo pump before discharge and acknowledged Resident 1's daughter contacted the facility upset because Resident 1 missed her scheduled morning TF due to the lack of equipment. The ADON stated Resident 1 had poor oral intake during her stay and relied on TF to meet her nutritional needs. The ADON stated that delaying TF placed Resident 1 at risk for continued nutritional decline, weight loss, and worsening health status. On 7/22/26 at 11:34 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 had a G-tube and confirmed Resident 1's two daughters received instructions on administering TF using the Kangaroo pump, syringe (a device used to inject fluids into or withdraw them from the body), and return demonstration before discharge but not for the TF bolus feed. LN 1 acknowledged the discharge care plan was not updated or individualized to reflect Resident 1's TF regimen, caregiver education, equipment needs, or specific discharge instructions and was essentially the same as the other sampled residents' (Resident 4 and Resident 5) discharge care plans. LN 1 stated an individualized discharge care plan is necessary to communicate Resident 1's specific health and safety needs, guide caregivers after discharge, promote continuity of care, and reduce the risk of re-hospitalization and further health decline. On 7/22/26 at 11:41 A.M., an interview was conducted with LN 2 via telephone. LN 2 stated he provided Resident 1's daughters with education on G-tube care including recognizing signs and symptoms of infection, verifying tube placement before initiating feedings, checking gastric (stomach) residuals (left over TF fluid), operating the Kangaroo pump for continuous TF, and notifying physician when residual volumes exceed 100 ml. LN 2 stated he did not teach Resident 1's daughters how to do a bolus TF because that was the active order at the time of discharge (7/16/26) for continuous TF and not a bolus. LN 2 acknowledged that if a bolus TF order had been received prior to discharge, he would have instructed Resident 1's daughters on the revised feeding method. LN 2 stated missing prescribed TF could place Resident 1, who had poor oral intake and depended on TF for nutrition, at risk for weight loss, nutritional decline, and worsening health status. On 7/22/26 12:14 PM ADON an interview and record review was conducted with the ADON. The ADON reviewed Resident 1's discharge care plan (along with Resident 4 and Resident 5) and acknowledged the discharge care plans were generic, contained copied information, and were not individualized to reflect each resident's (Resident 1, Resident 4 and Resident 5) specific discharge needs. The ADON stated discharge planning begins on admission and discharge care plan should be updated throughout a resident's (all facility residents) stay to communicate the resident's (all facility residents) stay to communicate resident's (all facility residents) individualized needs to the IDT, all residents, family, caregivers, and post discharge providers. The ADON stated an individualized discharge care plan is necessary to coordinate services, identify required equipment, provide caregiver education, promote continuity of care, reduce the risk of rehospitalization, and prevent further health decline. The ADON stated that Resident 1's revised order for the bolus TF was not discussed or provided education to Resident 1's daughters upon discharge. The ADON stated Resident 1 left the facility without a Kangaroo pump and had to miss her feeding because of the lack of equipment to administer the discharge TF instructions. The ADON stated that Resident 1's discharge process did not ensure Resident 1's discharge plan, physician orders, caregiver education, and necessary equipment were coordinated and implemented before discharge. On 7/22/26 at 12:29 P.M., an interview and record review was conducted with the Social Services Director (SSD). The SSD stated the facility's discharge care plans were not consistently revised or individualized to reflect residents' (all facility (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive person-centered discharge care plan for one of five sampled residents (Resident 2) within the required timeframe following the comprehensive assessment and failed to develop, implement, or revise Resident 2's discharge care plan before discharge. These deficient practices placed Resident 2 at risk for inadequate discharge planning, poor communication among the Intradisciplinary Team (IDT- a group of different experts, such as doctors, therapists, nurses and social workers, who work closely together) and post-discharge providers, interruption of needed services, and avoidable health decline or re-hospitalization. Findings: A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included history of Diabetes Mellitus Type II (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 2's minimum data set (MDS - a federally mandated resident assessment tool) dated 2/17/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 2 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 7/22/26 at 10:24 A.M., an interview and record review was conducted with the Social Service Assistant (SSA). The SSA stated that Resident 2 did not have a discharge care plan and acknowledged that one was never developed during Resident 2's stay at the facility. The SSA stated discharge planning should begin upon admission and the discharge care plan should have been initiated when Resident 2 was admitted to the facility. The SSA stated the IDT was actively seeking placement for Resident 2; however, Resident 2's care plan was never developed to identify Resident 2's discharge goals, anticipated discharge location, ongoing placement needs, or services required after discharge. The SSA stated the discharge care plan should have been updated throughout Resident 2's stay and finalized before discharge to ensure continuity of care and a safe transition to the assisted living facility that Resident 2 was discharged to. On 7/22/26 at 11:34 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 2 did not have a discharge care plan. LN 2 stated the discharge care plan should have been initiated within 48 hours of admission and revised throughout Resident 2's stay to reflect Resident 2's individualized discharge needs. LN 2 stated an individualized discharge care plan is necessary to communicate Resident 2's healthcare needs, coordinate discharge services, promote continuity of care, and reduce the risk of rehospitalization and health decline. On 7/22/26 at 12:14 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated we didn't even have a discharge care plan in place when it should have. Discharge care plans are needed to ensure safe and orderly discharges to prevent further health decline and safety. On 7/22/26 at 12:29 P.M., an interview and record review was conducted with the Social Services Director (SSD). The SSD stated Resident 2 did not have a discharge care plan and acknowledged the facility failed to initiate one within the required timeframe. The SSD stated discharge planning should begin on admission and be revised on a continuous basis throughout Resident 2's stay to reflect Resident 2's individual needs. The SSD stated the discharge care plan is intended to identify and coordinate medications, Durable Medical Equipment (DME), social services needs, discharge goals, and the responsibilities of the IDT to ensure a safe transition to the discharge location. The SSD stated that without a timely, individualized discharge care plan, important discharge needs could be missed, resulting in poor (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER LA Mesa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3780 Massachusetts Avenue LA Mesa, CA 91941	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordination of care, delays in necessary services, or equipment, complications after discharge, and an increased risk of hospitalization. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-centered dated March 2022, indicated .The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment(Admission, Annual or Significant Change in Status), and no more than 21 days after admission.		