STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055542	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care Center	8487 Magnolia Avenue Riverside, CA 92504

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 observation, interview, and record review, the facility failed to provide ongoing monitoring and assessment, for one of four residents reviewed (Resident 4), when there was a change of condition of increased drainage from the resident's neck lesions/wounds on January 14, 2026. In addition, there were no care plan developed to address Resident 4 who was at risk for infection due to increased wound drainage and odor. Findings:On February 3, 2026, at 9:53 a.m., an unannounced visit was conducted at the facility to investigate a complaint involving quality of care and treatment.On February 3, 2026, Resident 4's medical record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of tongue (a serious oral cancer) and tracheostomy (an opening in the neck leading directly to the windpipe).A review of Resident 4's Minimum Data Set (MDS- an assessment tool), dated December 12, 2025, indicated Resident 4 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 15 (cognitively intact).A review of Resident 4's COC (Change of Condition)/INTERACT ASSESSMENT FORM, dated January 14, 2026, at 3:02 p.m., indicated, .while dressing change.neck tumors .increased drainage and odor noted.recommendations: transfer to ER (emergency room).rule out infection.A review of Resident 4's Progress Notes, dated January 14, 2026, at 3:38 p.m., indicated, .called doctor.notified regarding resident refusal to be seen at hospital.continue monitor.increase the frequent of wound treatment.every shift.A review of Resident 4's Progress Notes, dated January 15, 2026 at 9:47 p.m., indicated, .per daughter.brought to ER.for the swelling to his neck and drainage.treatment to neck was administered at the hospital.to neck.lateral (side) areas.not the medial (middle).requests it be treated in the morning by the treatment nurse.A review of Resident 4's physician orders indicated the following:-On December 12, 2025, anterior (front) neck cancer lesion: cleanse with hibiclens (antiseptic and antimicrobial skin cleanser) solution pat dry and apply oil emulsion dressing and cover with ABD pad, every day shift.-On January 14, 2026, Cleanse with hibiclens solution pat dry and apply oil emulsion dressing and cover with ABD pad two times a day for Right lateral (side) posterior (back) neck cancer lesion.-On January 14, 2026, Cleanse with hibiclens solution pat dry and apply oil emulsion dressing and cover with ABD pad, two times a day for Right medial posterior neck cancer lesion.A review of Resident 4's progress note, titled, Skilled Evaluation, dated January 16, at 8:57 a.m., indicated, .skin.skin issue : 003: skin issue has not been evaluated.location: anterior neck.Further review of Resident 4's record indicated there was no documented evidence of the status or condition of the anterior, medial, or lateral neck wounds after there was a change in condition of the neck wounds on January 14, 2026. In addition, there was no updated care plan to address the increased drainage from the neck wounds or risk for infection. after the change of condition on January 14, 2026.On February 3, 2026, at 1:17 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated wound care on Resident 4's neck wounds was performed daily due to increased wound drainage. LVN 1 stated the wound (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings had approximately 50-100% saturation of drainage. On February 4, 2026, at 12:02 p.m., a concurrent interview and record review was conducted with Registered Nurse (RN) 1. RN 1 stated Resident 4's anterior, medial and lateral wounds were odorous prior to leaving the facility for his oncology appointment on January 15, 2026. RN 1 stated she did not change the dressings. RN 1 stated after Resident 4's oncology appointment, he went to the ER for further evaluation of his neck wounds swelling and drainage. RN 1 verified that on January 15, 2026, at 7:34 p.m., she spoke with the ER nurse for report and was informed that the drainage is to be expected and to just monitor and administer treatment as needed. RN 1 stated she was informed that Resident 4 would be discharged back to the facility once the tracheostomy site was cleaned. RN 1 stated on January 15, 2026, Resident 4's wounds were still odorous upon returning to facility from the ER. RN 1 stated Resident 4 only wanted the treatment nurse to change his wound dressings. RN 1 stated the resident's care plans should be updated after a change of condition is identified. On February 4, 2026, at 12:54 p.m., an interview was conducted with RN 2. RN 2 stated after a change of condition, the nursing staff will document a daily progress note, every shift to monitor the resident's condition and status related to the change of condition findings. RN 2 stated the care plans should be updated as well.On February 4, 2026, at 4:33 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated after a change of condition the nursing staff should monitor the resident for 72 hours and document in a progress note. The DON stated care plans should be updated if the change of condition is new. The DON stated the 72 hour monitoring process was not followed.A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated January 2012, indicated, .the nurse supervisor/charge nurse.will record.resident's medical record.information relative to changes .medical/mental condition or status. and .assessment related to the change in condition.will be documented . 72 hours.A review of the facility's policy and procedure titled, Documentation of Wound Treatments, dated September 2, 2022, indicated, .the following elements are documented as part of a complete wound assessment.color of wound bed.condition of peri-wound skin.presence, amount and characteristics of wound drainage.presence or absence of odor.A review of the facility's policy and procedure titled, Provision of Quality Care, dated December 19, 2022, indicated, .a comprehensive care plan.will be developed.for each resident.in accordance with.procedures for development.care plan.A review of the facility's policy and procedure titled, Skin Assessment, dated December 19, 2022, indicated, .documentation of skin assessment.document observations.type of wound.describe wound (measurements, color, drainage, odor) .