

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mission Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47374</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, handle, and serve food, in accordance with professional standards for food service safety for a highly vulnerable population of seven (7) residents who eat food from the facility kitchen, when, two (2) oven gloves were observed with dark stains thick brown/black substance on the fingers and multiple patches of white substance.</p> <p>This failure had the potential to result in cross contamination and cause food borne illnesses in a highly vulnerable population of seven (7) residents who eat food from the kitchen.</p> <p>Findings:</p> <p>On February 10, 2025, at 10:53 a.m., during the initial tour of the kitchen with the Dietary Manager (DM), two (2) oven gloves were observed hanging on a hook on the wall for use by the cook. The oven gloves were observed with dark stains and a thick brown/black substance on the finger tips and, along the posterior of the hand piece and multiple patches of white substance were observed up the sleeve of the oven gloves. One oven glove had worn area with loose threads with discoloration.</p> <p>In a concurrent interview, the DM stated the oven gloves should have been replaced and should not be used, due to possibility of cross-contamination and possible food borne illness to vulnerable residents.</p> <p>On February 10, 2025, at 10:58 a.m., [NAME] 1 stated the oven gloves should have been thrown away, to avoid cross-contamination and possibility of food-borne illness to the residents.</p> <p>On February 11, 2025, at 3:36 p.m., an interview was conducted with the Registered Dietician (RD). The RD stated the dirty oven gloves should not have been used and should have been laundered or replaced with new oven gloves. The RD further stated the oven gloves should not be used in that condition as it could cause cross-contamination and possible food borne illness to facility vulnerable residents.</p> <p>(continued on next page)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy and procedure titled, Food Safety and Food Storage, dated November 2024, indicated, .food will be .prepared, distributed and served .with professional standards of food service safety . food safety practices shall be followed throughout the entire food handling process .to include .other equipment that comes in contact with food .take precautions in critical control points to prevent, reduce, or eliminate potential hazards .all equipment used in the handling of food shall be clean and sanitized, and handled in a manner to prevent contamination .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure garbage and refuse were properly disposed off the facility grounds when multiple items were observed stored and stacked on top of each outside a trailer container.</p> <p>This failure had the potential to attract and harbor pest and rodents.</p> <p>Findings:</p> <p>On February 12, 2025, at 2:54 p.m., during a tour outside the facility with the Maintenance Supervisor (MS), multiple items of discarded wood, poles, signs, broken fans, metal frames, bath chairs, wooden pallets, bags of cement mix, and hoses stacked on top of each were observed beside the storage trailer. In a concurrent interview, the MS verified those items beside the storage trailer were discarded items. The MS stated discarded items should not be stored beside the storage trailer and should be disposed properly in the garbage binto prevent harboring of pests and rodents.</p> <p>A review of the facility's policy and procedures titled, Disposal of Garbage and Refuse, dated December 19, 2022, indicated, .Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized .Storage areas, enclosures, and receptacles for refuse shall be maintained in good repair and cleaned a frequency necessary to prevent them from developing a buildup of soil or becoming attractions for insects and rodents .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices were implemented when emergency water was stored in a clean environment.</p> <p>This failure had the potential for the spread of contaminants and/or infections to residents and staff.</p> <p>Findings:</p> <p>On February 12, 2025, at 2:54 p.m., an observation of the storage shed outside the facility was observed with the Maintenance Supervisor (MS). Several gallons of emergency water bottles were observed stored inside the storage shed. The water bottles were observed directly placed on the soiled and dusty floor next to chemical containers with warning labels. The top of the water bottles were observed with loose dirt. The water bottles were stored in a cluttered area with various items, including tools, soap dispensers, a broken fan, a broom, and mop sticks, and other items. The ceiling of the storage shed were observed to have loose particles and debris which had accumulated and fallen onto the water bottles. There was buildup of debris by the hole in the shed, which led to area filled with piled discarded items. The MS stated pests could get into the hole and further stated the water had been stored in the shed for many years.</p> <p>On February 13, 2025, at 5:46 p.m., an interview with the MS was conducted. The MS stated the water had always been stored in the storage shed in the back of the facility. The MS stated the emergency water bottles should be stored in a clean environment.</p> <p>A review of the facility's policy and procedures titled, Emergency Water Supply, dated December 19, 2022, indicated, .Water will be stored in medication rooms or other clean utility rooms until distributed to the individual resident room or other point-of-use areas, as needed .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>47374</p> <p>Based on observation, interview, and record review, the facility failed to provide the required bedroom space measuring at least 80 square feet per resident, in 15 resident rooms (Rooms: 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16, 17, and 18).</p> <p>On February 10, 2025, at 10 :00 a.m., an interview was conducted with the Director of Nursing (DON) regarding the room sizes for resident rooms 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16, 17, and 18. The DON stated the rooms did not meet the space requirement of at least 80 square feet per resident in the above mentioned resident rooms. The DON stated the facility has a waiver for the rooms.</p> <p>During the survey dates February 10,11, 12 and 13, 2025, the above listed rooms were observed at different times of the day. There were no adverse effects that impacted the quality of life of the residents who resided in the rooms as observed during the survey dates.</p> <p>On February 12, 2025, at 10:15 a.m., the DON provided the request for room waivers for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16, 17, and 18.</p> <p>On February 13, 2025, during interviews with the residents in rooms 6A, 10A, 10C, 17B and 18A, the residents stated there were no issue with room size or crowding. During interview with the nursing staff, they stated they have a good system for working in the rooms and have not had any issues attending to their residents.</p> <p>The facility requested a continued waiver for Rooms 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16, 17, and 18. Approval of the waiver is recommended. Granting this waiver will not adversely affect the residents' health and safety and is in accordance with the special needs of the residents.</p>		