

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2025
NAME OF PROVIDER OR SUPPLIER Mission Skilled Nursing & Subacute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 410 North Winchester Boulevard Santa Clara, CA 95050	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse for one of three sampled residents (Resident 1). This failure had the potential to delay abuse investigations and compromise Resident 1's safety. Review of Resident 1's medical record indicated he was admitted on [DATE] and had the diagnosis of spinal stenosis (the space inside the bones of the spine gets too small), anxiety disorder (a mental health condition), difficulty in walking, and muscle weakness. Review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/1/25, indicated his Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (BIMS score of 13-15 indicates cognitively intact). During a telephone interview with Resident 1 on 6/3/25, at 12:01 p.m., he stated that he was assaulted by his co-resident and did not feel safe in the facility. Resident 1 stated that his co-resident came to him in the middle of the night and touched his belongings, like bed sheets on 2/20/25. Resident 1 further stated that he reported the assault to the Social Service Director (SSD), but he did not report to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities). Review of Resident 1's Nursing Progress Notes, dated 2/20/25 at 6:05 a.m., indicated that at around 4:30 a.m., resident yelling & busting the call light multiple times. Resident yelling to the staff to move the roommate immediately/right now. Resident c/o (complain of) roommate smelly, noisy & kept getting up & going to his side. Review of Resident 1's Social Service Progress Notes, dated 2/20/25 at 8:48 p.m., indicated that Resident refusing to have new roommate placed in room. Resident stated it is due to the roommate he received on 2/19/25 not going well. Resident's main concern is having a roommate who is able to get out of bed and come to his side of the room. Review of Resident 1's medical record on 7/16/25 revealed there was no documentation for the allegation of assault which reported by Resident 1. During an interview with the SSD on 6/3/25 at 2:10 p.m., he stated Resident 1 reported that he was assaulted by his roommate on 2/20/25. The SSD stated Resident 1 reported that his roommate came to him and grabbed his covers, like a blanket; Resident 1 denied any physical contact from his roommate. The SSD further stated that he investigated and concluded Resident 1's report was not an allegation of abuse. Review of the SSD's Investigation provided by the SSD on 6/3/25 indicated Incident: Resident 1 reported he was assaulted by his roommate. Asked resident to elaborate on what he meant by assaulted 'he stated his old roommate was grabbing at his covers.' Asked resident if he was hit or if other resident made physical contact with him, he replied 'no'. During an interview with the SSD on 6/3/25 at 3:09 p.m., he stated he reported his investigation to the Director of Nursing (DON). During an interview with the DON on 6/3/25 at 3:15 p.m., she confirmed that she received the SSD's Investigation about Resident 1's report. The DON stated that she and the SSD concluded that Resident 1's report was not an allegation of abuse after the investigation performed by the SSD. The DON stated Resident 1's report was not reported to the California Department of Public Health (CDPH) or Ombudsman. During an interview with the DON on 7/16/25 at 10:50 a.m., she stated that the SSD clarified the meaning of the assault reported by Resident 1; Resident 1 stated the meaning of the assault was his roommate grabbed his sheet; Resident 1 was alert and oriented, he was able to define the meaning of the assault. The DON stated she and the SSD concluded that Resident 1's report was not an allegation of abuse. Review of the facility's policy and procedure (P&P) titled Alleged or Suspected Abuse and Crime Reporting, revised 10/2022, indicated, definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Alleged violation is a situation or occurrence that is observed or reported. During an interview and the facility's policy titled Alleged or Suspected Abuse and Crime Reporting review with the DON on 7/16/25 at 11 a.m., she acknowledged the definitions of abuse and alleged violation. During an interview and record review with the DON on 7/16/25 at 11:10 a.m., she confirmed there was no documentation of Resident 1's allegation of assault. The DON stated there was no documentation about Resident 1's report in his chart because Resident 1's report was a complaint not an allegation of abuse. The DON further stated Resident 1's report was discussed during the facility morning meeting without documentation, also the SSD's investigation was internal investigation. During an interview with the Administrator (ADM) on 7/16/25 at 11:30 a.m., he stated he was not aware of Resident 1's allegation of assault on 2/20/25; the SSD's investigation was not reported to him. The ADM stated it was reported during the facility's morning meeting that Resident 1 complained about his roommate pulling his sheets. The ADM stated he was the facility's abuse coordinator</p>		