STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055991	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Park Healthcare Center	623 W Junipero St Santa Barbara, CA 93105

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 44589 Based on record review and interview, the facility failed to ensure resident ' s representative (RR) was invited and included in the formulation of a person-centered baseline care plan (CP -implementation of care plan goals and interventions) that was to be done within 48 hours of resident ' s admission when the facility discussed the initial plan of care to one of two cognitively impaired (problems with ability to think, learn and remember) sampled residents (Resident 1). This failure resulted in RR being uninformed and was not given at the opportunity to participate in making decisions for Resident 1 ' s initial plan of care, treatment, and healthcare goals that could affect Resident 1 ' s care and quality of life. Findings: During a review of the facility ' s policy and procedure (P&P), titled, Care Planning, dated 10/2023, the P&P indicated, in part, I. The facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission .A. The facility will invite the resident, if capable, and their family to the care planning meetings and use its best effort to schedule care planning meetings at times convenient for the resident and family .B. IDT meetings may be conducted via teleconference. During a review of Resident 1 ' s admission packet (AP), titled, Health & Safety Code 1599, undated, the AP indicated, Written policies regarding the rights of patients shall be established and shall be available to patient, to any guardian, next of kin, sponsoring agency or representative payee, and to the public.in part . Any rights under this chapter of a patient judicially determined to be incompetent, or who is found by his physician to be medically incapable of understanding such information, or who exhibits a communication barrier, shall devolve to such patient ' s guardian, conservator, next of kin, sponsoring agency or representative payer, except when the facility itself is the representative of the payer. During a review of Resident 1 ' s Nursing Admission Assessment (NAA),dated 8/2/24, the NAA neurological assessment (assessing mental status and level of consciousness) indicated, Resident 1 was alert, oriented to person, had difficulty in new situations. Further review of NAA, dehydration screening functional signs indicated, that Resident 1 had cognitive impairment. (continued on next page)

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
	055991	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Park Healthcare Center	623 W Junipero St Santa Barbara, CA 93105

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s History and Physical (H&P),dated 8/3/24, the H&P indicated, Resident 1 can make needs known but cannot make medical decisions. During a review of Resident 1 ' s MDS section C for mental status, dated 8/5/24, Resident 1 ' s had a Brief Interview for Mental Status (BIMS) of 08, score between 13-15, cognitively intact, score 8-12, moderate impairment, and a score of 0-7, severe impairment. During a review of Resident 1 ' s CP for cognitive functioning(mental status), dated 8/4/24, the CP indicated, that Resident 1 had impaired cognitive functioning and thought processes (ability to use, analyze and understand information) related to short term memory (ability to store information for short period of time) loss. Resident 1 ' s CP interventions include, to communicate with resident/family/caregivers regarding resident ' s capabilities and needs, to cue (hint) resident and supervise as needed and to present just one thought, idea, question, or command at a time. During a review of the document titled, Baseline Care Plan Summary (BCPS), dated 8/2/24, the BCPS indicated, the initial plan of care was discussed with Resident 1 on 8/3/24. Further review of the BCPS, the BCPS had missing RR signature. and no documentation if the RR was invited for the initiation of Resident 1 ' s baseline CP or if the initial plan of care was discussed with the RR via phone. During an interview on 9/11/24, at 11:01 a.m. with the treatment nurse (TXN), TXN verbalized, that Resident 1 had cognitive impairment but was able to make her needs known such as pain or likes and dislike. LN 1 further verbalized, that Resident 1 had two representatives that were very involved with resident ' s care, one being more involved than the other. During a review of Resident 1 ' s clinical record from 8/2/24 to 8/7/24, six days after Resident 1 ' s admission, no documentation of the RR ' s attendance when the baseline care plan was discussed with Resident 1. Further review of Resident 1 ' s clinical record indicated, it was during the care conference on 8/8/24 when the RR attended the meeting. During a concurrent record review and interview on 9/25/24, at 3:42 p.m. with the Director of Nursing (DON), and LN 1, the Resident 1 ' s cognitive status on NAA, H&P, CP, and the BCPS were reviewed, indicating Resident 1 ' s cognitively impairment. LN 1 claimed that the RR was present on 8/3/24 when baseline care plan summary was discussed with Resident 1, LN 1 was unable to prove the claim of RR ' s attendance. The DON acknowledged the RR ' s missing signature on the BCPS. The DON further acknowledged, that signature should have been obtained at the time of the meeting to prove RR ' s attendance but it was missed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055991	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Park Healthcare Center	623 W Junipero St Santa Barbara, CA 93105

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44589 Based on record review and interview, the facility failed to provide resident or the resident ' s representative (RR) a summary of the baseline care plan (initial plan of care) for one of two sampled residents ' (Resident 1). This failure resulted in RR to have no knowledge of the initial care plan goals and interventions being provided to Resident 1. Findings: During a review of the facility ' s policy and procedure (P&P) titled, Care Planning, dated 10/2023, the P&P indicated, in part . I. The facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission .Once the Baseline Care Plan is completed, the Facility must provide the resident and /or the resident ' s representative with a written summary of the Baseline Care Plan that includes: A. Initial goals based on admission orders. B. Physician ' s orders. C. Dietary orders. D. Therapy Services. E. Social services. F. PASARR recommendations, if applicable .The medical record must contain evidence that the summary was given to the resident and/or resident ' s representative. During a review of the document titled, Baseline Care Plan Summary (BCPS), dated 8/2/24, the BCPS indicated, the Care Plan was discussed with Resident 1 on 8/3/24 during the initial care plan meeting. Further review of the BCPS, the BCPS had missing RR signature and no documentation if the Care Plan was discussed with the RR present during the meeting. During an interview on 9/12/24, at 11:45 a.m. with the Licensed Vocational Nurse (LN 1), LN 1 stated, details of Resident 1 ' s plan of care was discussed with the RR. LN 1 was unsure if RR was provided with BCPS at the time of the meeting. During an interview on 9/23/24, at 10:52 a.m. with the Assistant Administrator (AADM), the AADM was unable to provide proof of RR receiving the Baseline Care Plan Summary. AADM acknowledged, that the BCPS was missed. Further interview on 9/23/24 at 1:04 p.m. with the Director of Nursing (DON), the DON confirmed that the BCPS was not provided to the RR.