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	12/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51682 Based on observation, interview, record review, and facility policy review, the facility failed to ensure an incident report was completed and a post-fall assessment and investigation was completed after 1 (Resident #1) of 1 sampled resident reviewed for accidents sustained a fall. Findings included: A facility policy titled, Fall Risk Assessment, dated 10/01/2023, indicated C. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention or the if the resident caught themselves, is considered a fall. D. A fall without injury is still a fall. A facility policy titled, Fall Management Program, dated 10/01/2023, indicated IV. Post-Fall A. Following a resident's fall, the licensed nurse will complete an incident report and a Post-Fall Assessment & Investigation within 24 hours or as soon as practicable. B. The Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated. An Admission Record indicated the facility admitted Resident #103 on 11/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of syncope and collapse, orthostatic hypotension, abnormalities of gait, need for assistance with personal care, glaucoma, history of falls, and use of anticoagulants. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed Resident #103 had a Brief interview of Mental Status (BIMS) of 15, which indicated the resident had intact cognition. The MDS indicated the resident required partial/moderate assistance with toileting hygiene. During an interview on 12/10/2024 at 2:17 PM, Resident #103 stated they had a fall over the prior weekend and was still sore on their left side. Resident #103 stated the fall occurred the bathroom and that a staff member was at the bathroom door, but distracted when they fell . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/10/2024 at 3:30 PM, the Director of Nursing (DON) asked Resident #103 to roll over in bed and the surveyor visualized a large dark purple discoloration on the left flank region of Resident #103. Resident #103 reported they fell over the weekend during the day shift and a female staff member was present when they fell . According to Resident #103, as they stood at the sink in, they fell . Resident #103 stated the female staff member that assisted them to the bathroom, stated they were distracted at the time of the fall and did not watch the resident. Resident #103 stated a second staff member assisted the female staff member in getting them to a standing position. Resident #103 stated no one performed a skin assessment to determine if there were any injuries after the fall. The DON stated she was not aware the resident had bruising or had a fall. During an interview on 12/10/2024 at 4:48 PM, Licensed Vocational Nurse (LVN) #4 stated she was on duty and assigned to Resident #103 on Saturday 12/07/2024 during day shift when the resident sustained a fall in their bathroom. LVN #4 stated she could not recall the name of the nurse aide (NA), but she was notified by the NA that as the resident stood in the bathroom, the resident got dizzy, lost their balance and dropped onto the toilet riser. LVN #4 stated she did not consider it a fall as the resident did not initially complain of pain. LVN #4 acknowledged she did not complete an incident report or assess the resident for injuries after she was notified the resident had a fall. According to LVN #4, she assisted the NA to stand the resident and walked with the resident back to their bed and she continued on with caring for the other residents. During an interview on 12/11/2024 at 10:37 AM, NA #6 stated NA #7 took Resident #103 to the bathroom and when she went to ask NA #7 about another resident, NA #7 turned to talk to her and that was when Resident #103 fell from a standing position. NA #6 stated she went to the get LVN #4. According to NA #6, after LVN #4 arrived in the resident's room and the resident was walked backed to their bed, she left and did not do anything else with Resident #103 for the remainder of her shift. During an interview on 12/11/2024 at 11:52 AM, NA #7 stated she recalled Resident #103 fell around 10:30 AM on 12/07/2024. NA #7 stated she was not the NA to place the resident on the toilet, but as the resident stood to wash their hands, another NA approached the door to ask her something about another resident and in the process of her replying to the other NA, she took her eyes off the resident, the resident lost their balance and landed on the back of the toilet. NA #7 stated she did not witness the fall that she only heard it. NA #7 stated she asked the other NA to get the nurse. According to NA #7, when the nurse arrived, the nurse asked the resident if they had pain and the resident stated they had pain on their left side, felt dizzy, and out of breath. NA #7 stated the nurse informed her that Resident #103 had hypotension and their blood pressure would rise and fall. Per NA #7, she was unaware and that she just saw a call light on, answered the call light, and did not want to leave the resident alone in the bathroom. NA #7 stated the resident was okay to stand, so she and the nurse walked the resident back to their bed. During an interview on 12/11/2024 at 1:12 PM, the Director of Nursing (DON) stated a fall was to be considered whether a resident landed on the floor or not. The DON stated Resident #103's fall should have been investigated and a full assessment of the resident should have been completed. During an interview on 12/11/2024 at 1:34 PM, the Administrator stated a loss of balance was considered a fall. The Administrator stated the nurse should have done an assessment and documented the resident experienced a fall. Per the Administrator, the nurse and the NA should have communicated all the details of the resident's fall so that an investigation could have been completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46194 Based on interview, record review, and facility policy review, the facility failed to ensure pain medication was available for administration for 1 (Resident #267) of 3 sampled residents reviewed for pain management. Findings included: A facility policy titled, Ordering and Receiving Controlled Medications, dated 01/2020, indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by stated law, are subject to special ordering, receipt, and record keeping requirements in the nursing care center in accordance with federal and state laws and regulations. The nursing care center obtains and keeps current and on file any permits require by state agencies. The policy specified, If only one refill remains or only a partial fill quantity remains, the pharmacy will simultaneously dispense the remaining fill, and, if necessary proactively seek out a new, complete prescription form the prescriber for a new prescription upon request for a medication with no remaining fills available. An Admission Record indicated the facility admitted Resident #267 on 11/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic pain syndrome, restless leg syndrome, myasthenia gravis, and malignant neoplasm of the left breast. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2024, revealed Resident #267 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had occasional pain and received as-needed pain medication. Resident #267's care plan, included a focus area initiated 12/04/2024, that indicated the resident had pain related to a recent surgery. Interventions directed staff to administer the resident's pain medications as ordered. Resident #267's Order Summary Report which contained active orders as of 12/10/2024, revealed an order dated 11/29/2024, for acetaminophen oral tablet 500 milligrams (mg), give two tablets by mouth every six hours as needed for mild to moderate pain and an order dated 11/29/2024, for tramadol hydrogen chloride oral tablet 50 mg, give one tablet by mouth every six hours as needed for pain. Resident #267's occupational therapy note dated 12/09/2024, indicated Resident #267 refused all four attempts for occupational therapy. According to the occupational therapy note, the resident had difficulty with medications and physician orders and requested for their occupational therapy to be placed on hold until all was sorted out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/2024 at 9:22 AM, Resident #267 stated the facility was out of their pain medication on 12/08/2024. According to Resident #267, the night nurse on 12/08/2024 contacted the physician several times; however, the physician did not respond. Resident #267 stated they were not in pain at the present time, but they would refuse therapy on 12/09/2024 because they did not have any pain medication and therapy was painful. On 12/10/2024 at 11:54 AM, Occupational Therapist (OT) #8 stated when she entered Resident #267's room, the resident informed her about their medications. OT #8 stated the resident did not want to risk being in pain and the Tylenol would not have been enough. OT #8 stated she went back to the resident four times and each time, the resident stated the facility did not have their pain medication and that nursing was working on it. OT #8 stated the resident was not in pain, but was afraid to chance movement and potential pain. On 12/10/2024 at 3:36 PM, Licensed Vocational Nurse (LVN) #1 stated when he came in to work and took count for the medication cart, the resident did not have any pain medication on the medication cart. LVN #1 stated when he realized the resident did not have any pain medication, he called the on-call physician and followed up with the nurse practitioner when the on-call physician did not return his call. Per LVN #1, he did not get a response from neither the nurse practitioner nor the on-call physician, so he administered Tylenol to the resident. Per LVN #1, the resident told him that they usually wanted their tramadol pain medication before therapy. On 12/10/2024 at 4:04 PM, LVN #3 stated she administered the last tramadol tablet to Resident #267. Per LVN #3, she did not reorder the medication as it was reported to her that the medication had already been reordered. On 12/10/2024 at 4:27 PM, the Pharmacist stated there were no prior requested refills for Resident #267's tramadol pain medication. The Pharmacist stated the pharmacy received a prescription on 12/09/2024 at 1:48 PM from the physician to dispense tramadol for the resident and the pharmacy sent 90 tablets to the facility on [DATE] in the afternoon delivery. The Pharmacist stated the pharmacy would not know when the resident was out of medication as the facility staff had to request a refill. On 12/11/2024 at 8:19 AM, the Director of Nursing (DON) stated it was up to the nurses to determine when to order the resident's medications. The DON stated the nurses informed her that they ordered the resident's medications; however, the pharmacy indicated the medication had not been reordered. According to the DON, there appeared to be a problem with the integration process between the facility and the pharmacy. Per the DON, there was a break in the ordering process. On 12/11/2024 at 8:58 AM, the Administrator stated he expected staff to have the medication in the facility, and if they did not have the medications on hand, he expected staff to use every route to ensure the medications were there as soon as possible.