STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056122	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrae Care Center	33 Mateo Avenue Millbrae, CA 94030

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a person-centered care plan for two of two sampled residents (Resident 1, and Resident 2) when:Smoking and going out on pass (when a resident leaves the facility temporarily) was not addressed for Resident 1.Going out on pass was not addressed for Resident 2. The facility failure had the potential for the residents not to receive necessary care and services. A review of the face sheet indicated Resident 1 was admitted with diagnoses including heart failure (when the heart muscles do not pump as strong as it should) and diabetes (abnormally high blood sugar level).A review of the Minimum Data Set (MDS, a standard assessment tool) dated 1/15/26, indicated Resident 1 was cognitively intact. The MDS further indicated Resident 1 was independent with all aspects of activities of daily living (ADL).During a concurrent interview and record review on 1/28/26, at 1:47 PM, with Registered Nurse (RN) 1, the physician order for 1/2026, indicated Resident 1 may smoke. The physician order further indicated Resident 1 may go out on pass. RN 1 reviewed the care plan and stated that there was no care plan completed to address smoking. On further review of the care plan, RN 1 stated that there was no care plan completed to address going out on pass for Resident 1. 2. A review of the face sheet indicated Resident 2 was admitted with diagnoses including cellulitis of the back. A review of MDS dated [DATE], indicated Resident 2 had little to no cognitive impairment. The MDS further indicated Resident 2 was independent with all aspects of ADLs.During a concurrent interview and record review on 1/28/26, at 2 PM, with RN 1, the physician order for 1/2026, indicated Resident 2 may smoke. RN 1 reviewed the care plan and stated that there was no care plan completed to address smoking for Resident 2. During an interview on 1/28/26, at 3 PM, the Administrator stated the Director of Nursing (DON) was responsible for ensuring that resident care plans were completed.The DON was not available for interview. A review of the facility Policy and Procedure titled Comprehensive Plan of Care dated 12/2016, indicated, .It is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.The comprehensive plan of care will include: Address resident's individual needs, strengths, and preferences; reflect current standards of practice; reflect interventions to meet both short- and long-term objectives . include interventions to attempt to manage risk factors; be developed by the interdisciplinary team (IDT) that includes the attending physician, a registered nurse, and other appropriate staff as determined by the resident's needs; be periodically reviewed and revised by IDT as changes in the resident care and treatment occur; reflect participation of the resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to update the care plan for one of one sampled resident (Resident 3) after Resident 3 had two fall incidents.The failures had the potential to put the resident at risk of not receiving appropriate care. A review of the face sheet indicated Resident 3 was admitted with diagnoses including dementia (decline in memory or decision-making ability), muscle weakness, and abnormalities in gait (how a person walks) and mobility.A review of the Interdisciplinary Team notes dated 1/20/26, indicated Resident 3 had two fall incidents on 1/14/26.During a concurrent observation and interview on 1/28/26, at 12:49 PM, with Resident 3, Resident 3 was sitting up in a wheelchair in the hallway, alert, verbally responsive, calm and pleasant. Resident 3 was able to state his name. Resident 3 did not know his current location and the reason for residing in the facility. When asked about the fall incidents, Resident 3 stated he was feeling sleepy, had tried to walk, and needed to use the bathroom. During an interview on 1/28/26, at 1:17 PM, the Licensed Vocational Nurse (LVN)1 stated that care plans are initiated when there is a change in condition like a fall incident. LVN 1 further stated that care plans are reviewed and updated after each fall incident. LVN 1 stated she has not received an in-service on care planning.During a concurrent interview and record review on 1/28/26, at 1:26 PM, with LVN 2, LVN 2 reviewed the care plan for Resident 3 and stated that the care plan did not address the two fall incidents that occurred on 1/14/26. LVN 2 stated she has not received an in-service on care planning. During an interview on 1/28/26, at 3 PM, the Administrator stated the Director of Nursing (DON) and the Director of Staff Development (DSD) were responsible for providing in-services to the licensed nurses.On 1/28/26, the DON and the DSD were not available for interview. A review of the facility policy and procedure titled Person Centered Plan of Care dated 12/2016, indicated .The person-centered care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental and psychological well-being that will accommodate resident need. The person centered care plan will include: reflect current standards of professional practice.reflect interventions to meet both short- and long-term resident goals; include interventions to prevent avoidable decline in function or functional level;, include interventions to attempt to manage risks factors. be developed by an interdisciplinary team (IDT) that includes the attending physician, a registered nurse, and other appropriate staff as determined by the resident's needs; be periodically reviewed and revised by the IDT as changes in the resident's care and treatment occur; reflect participation of the resident, resident's family, or the resident's legal representative.A review of the facility Policy and Procedure titled; Post Fall Management Program dated 12/2016, indicated .Plan of Care Revision: A resident's condition and the effectiveness of the plan of care interventions will be evaluated if revisions are necessary to justify for continuing the existing plan based upon the following: The outcome and/or effects of goals and interventions, Resident failure to comply with the plan of care and interventions.