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	06/25/2026

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.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the attending physician reviewed the resident's total program of care and failed to write, sign, and date progress notes as required for 3 out of 12 sampled residents (Residents 1, 2, and 3). This failure had the potential to result in the residents not receiving timely evaluation of their medical regimen and necessary adjustments to treatments, placing the residents at risk for unmet medical needs and a decline in physical, mental, or psychosocial wellˆbeing.During a review of Resident 1's Electronic Medical Record (EHR), the Resident 1's EHR indicated Resident 1 was admitted on [DATE] and has a Brief Interview for Mental Status (BIMS) Summary Score of 14 as of 06/01/2026. The Brief Interview for Mental Status (BIMS) is a short assessment used in nursing facilities to evaluate a resident's memory and thinking abilities. A score of 13 to 15 indicates intact cognition, meaning the resident is thinking clearly, remembers well, and can make decisions without noticeable cognitive problems. A score of 8 to 12 reflects moderate cognitive impairment, meaning the resident may have some difficulty with memory, learning new information, or staying oriented, though they can usually still take part in simple decisionˆmaking. A score of 0 to 7 indicates severe cognitive impairment, meaning the resident has significant problems with memory and thinking and may require substantial support with daily decisionˆmaking.During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 1's EHR was reviewed. The record showed that the last physician progress note was dated 03/16/2026, which was 101 days before the interview. The Medical Records Director confirmed that 03/16/2026 was the most recent physician progress note in Residentˆ1's EHR. A records request was submitted after the interview with the MRD.During a review of History and Physical Note for Resident 1, dated 05/28/2022, the History and Physical Note indicated that the author's credentials were not identified. This was the only physician note the facility provided for Residentˆ1 for the year 2022.During a review of History and Physical Note for Resident 1, dated 05/16/2023, the History and Physical Note indicated that the author's credentials were not identified. This was the only physician note the facility provided for Residentˆ1 for the year 2023.During a review of Long Term Care (LTC) Skilled Nursing Facility (SNF) Monthly Progress Note for Resident 1, dated 10/15/2024, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 10/15/2024. Most of the information documented in the 10/15/2024 LTC SNF Monthly Progress Note appeared to be cloned from the progress note completed on 11/15/2024. Cloned means the information was copied from one note to another, instead of being newly written. It suggests the content wasn't updated for the resident's current condition but was repeated from a previous entry.During a review of Acute Skilled Nursing Facility Visit Note for Resident 1, dated 04/16/2026, the Acute Skilled Nursing Facility Visit Note indicated that the note remained unsigned and its status was listed as open. The note did not reflect the resident's overall program of care, including the resident's current condition, progress, problems in maintaining or improving physical, mental, and psychosocial well-being, or clinical decisions regarding the continued appropriateness of the resident's medical regimen. The note was not available for review during the (continued on next page)

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

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent interview and record review on 06/25/2026 at 3:21 PM with the MRD and was only made available after a record request was submitted following the interview.During a review of Long Term Care (LTC) Skilled Nursing Facility (SNF) Monthly Progress Note for Resident 1, dated 06/08/2026, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 06/08/2026. Most of the information documented in the 06/08/2026 LTC SNF Monthly Progress Note appeared to be cloned from the progress note completed on 03/16/2026 and the LTC SNF Annual History and Physical Note completed on 05/14/2026.During a review of Resident 2's Electronic Medical Record (EHR), the Resident 2's EHR indicated Resident 2 was admitted on [DATE] and has a BIMS Summary Score of 11 as of 12/02/2025. During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 2's EHR was reviewed. The record showed that the last physician progress note was dated 01/19/2026, which was 157 days before the interview. The Medical Records Director confirmed that 01/19/2026 was the most recent physician progress note in Resident^2's EHR. A records request was submitted after the interview with the MRD.During a review of LTC SNF Annual History and Physical Note for Resident 2, dated 11/15/2024, the LTC SNF Annual History and Physical Note indicated that the note remained unsigned and in draft status, bearing a draft timestamp of 08/26/2025 at 11:40 AM--284 days after the documented date of service.During a review of Physician Progress Note for Resident 2, dated 12/18/2024, the Physician Progress Note indicated that this entry constituted a late entry for a physician encounter for 12/18/2024. Most of the information documented in the 12/18/2024 Physician Progress Note appeared to have been cloned from the progress note completed on 11/15/2024.During a review of Physician Progress Note for Resident 2, dated 11/15/2024, the Physician Progress Note indicated that this entry constituted a late entry for a physician encounter for 11/15/2024. Most of the information documented in the 11/15/2024 Physician Progress Note appeared to have been cloned from the progress note completed on 10/18/2024.During a review of Physician Progress Note for Resident 2, dated 10/18/2024, the Physician Progress Note indicated that this entry constituted a late entry for a physician encounter for 10/18/2024. Most of the information documented in the 10/18/2024 Physician Progress Note appeared to have been cloned from the progress note completed on 09/23/2024.During a review of LTC SNF Monthly Note for Resident 2, dated 03/15/2025, the LTC SNF Monthly Note indicated that the note remained unsigned and in draft status, bearing a draft timestamp of 10/12/2025 at 1:23 AM--211 days after the documented date of service.During a review of LTC SNF Monthly Note for Resident 2, without a date of service, the LTC SNF Monthly Note indicated that the note remained unsigned and in draft status, bearing a draft timestamp of 08/20/2025 at 11:37 PM.During a review of Resident 3's Electronic Medical Record (EHR), the Resident 3's EHR indicated Resident 3 was admitted on [DATE] and has a BIMS Summary Score of 06 as of 05/27/2026. During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 3's EHR was reviewed. The record showed that the last physician progress note was dated 03/03/2026, which was 114 days before the interview. The Medical Records Director confirmed that 03/03/2026 was the most recent physician progress note in Resident^3's EHR. A records request was submitted after the interview with the MRD.During an interview on 06/25/2026 at 5:05 PM with Resident 3, Resident^3 stated that they have not been seen by a physician at the facility since becoming a resident, but they have seen physicians outside the facility several times.During a review of SNF Progress Note for Resident 3, dated 02/28/2026, the Physician Progress Note indicated that this entry constituted a physician encounter for 02/28/2026. Most of the information documented in the 02/28/2026 SNF Progress Note appeared to have been cloned from the SNF Progress Note completed on 02/10/2026.During a review of SNF Progress Note for Resident 3, dated 03/03/2026, the Physician Progress Note indicated that this entry constituted a physician encounter for 03/03/2026. Most of the information documented in the 03/03/2026 SNF Progress Note appeared to have been cloned from the SNF Progress Note completed on 02/28/2026.During a review of the facility's policy and procedure titled Physician (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services, dated June 2022, indicates that the policy requires the attending physician to:Review the resident's total program of care at each visit, including all medications and treatments.Evaluate the resident's current condition and determine whether the existing medical regimen remains appropriate.Write, sign, and date a progress note at every physician visit, documenting the evaluation and care review.Complete all documentation-whether in the paper chart or electronic record-in accordance with facility practices, and sign and date all medical orders associated with the visit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure required faceˆtoˆface physician visits were conducted and that the corresponding documentation was completed and maintained in the residents' medical records, as required, for 5 of 12 sampled residents (Residents 1, 2, 3, 4, and 5). This failure has the potential to result in negative outcomes for residents, including delays in identifying changes in condition, missed opportunities for timely medical interventions, unmanaged or worsening chronic conditions, increased risk of avoidable hospitalizations or emergency department visits, inadequate medication management, and overall decline in residents' health status due to lack of timely clinical oversight.During a review of Resident 1's Electronic Medical Record (EHR), the Resident 1's EHR indicated Resident 1 was admitted on [DATE] and has a Brief Interview for Mental Status (BIMS) Summary Score of 14 as of 06/01/2026. The Brief Interview for Mental Status (BIMS) is a short assessment used in nursing facilities to evaluate a resident's memory and thinking abilities. A score of 13 to 15 indicates intact cognition, meaning the resident is thinking clearly, remembers well, and can make decisions without noticeable cognitive problems. A score of 8 to 12 reflects moderate cognitive impairment, meaning the resident may have some difficulty with memory, learning new information, or staying oriented, though they can usually still take part in simple decisionˆmaking. A score of 0 to 7 indicates severe cognitive impairment, meaning the resident has significant problems with memory and thinking and may require substantial support with daily decisionˆmaking.During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 1's EHR was reviewed. The record showed that the last physician progress note was dated 03/16/2026, which was 101 days before the interview. The Medical Records Director confirmed that 03/16/2026 was the most recent physician progress note in Residentˆ1's EHR.During an interview on 06/25/2026 at 4:54 PM with Resident 1, Residentˆ1 stated that their most recent physician visit occurred on 06/10/2026 with a physician outside the facility, though they could not recall the physician's name. Residentˆ1 further explained that physicians do not come to see them at the facility and that the only time they were seen by a physician on-site was when they first arrived about five years ago.During a review of Long Term Care (LTC) Skilled Nursing Facility (SNF) Monthly Progress Note for Resident 1, dated 03/16/2026, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 03/16/2026, and the physician progress note was completed and signed on 03/23/2026 at 5:45 PM. The physician encounter is 209 days after the previous physician LTC SNF Monthly Progress Note dated 08/19/2025.During a review of LTC SNF Monthly Progress Note for Resident 1, dated 08/19/2025, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 08/19/2025, and the physician progress note was completed and signed on 08/20/2025 at 10:41 PM, which is 96 days after the previous physician encounter for an LTC SNF Annual History & Physical on 05/15/2025.During a review of Long Term Care (LTC) Skilled Nursing Facility (SNF) Monthly Progress Note for Resident 1, dated 04/15/2025, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 04/15/2025, and the physician progress note was completed and signed on 09/04/2025 at 11:32 PM. The physician encounter is 90 days after the previous physician LTC SNF Monthly Progress Note dated 01/15/2025.During a review of a History & Physical Note for Resident 1, dated 05/16/2023, the History & Physical Note indicated that the author's credentials could not be verified and the electronic signature could not be confirmed as valid. The History & Physical Note was completed 518 days after the previous physician LTC SNF Monthly Progress Note dated 10/15/2024. During a review of a History & Physical Note for Resident 1, dated 05/28/2022, the History & Physical Note indicated that the author's credentials could not be verified and the electronic signature could not be confirmed as valid. The History & Physical Note was completed 353 days after the previous physician LTC SNF Monthly Progress Note dated 05/16/2023. The facility failed to ensure that (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident^1 received physician visits at the required frequency and within the allowable timeframes. Several physician encounters occurred outside the ^70^day window permitted for required visits (including the 10^day grace period). The facility also failed to ensure that physician visit notes were uploaded into Resident^1's electronic health record in a timely manner, limiting clinical staff's ability to review and respond to the resident's ongoing medical needs.During a review of Resident 2's Electronic Medical Record (EHR), the Resident 2's EHR indicated Resident 2 was admitted on [DATE] and has a BIMS Summary Score of 11 as of 12/02/2025. During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 2's EHR was reviewed. The record showed that the last physician progress note was dated 01/19/2026, which was 157 days before the interview. The Medical Records Director confirmed that 01/19/2026 was the most recent physician progress note in Resident^2's EHR.During an interview on 06/25/2026 at 5:08 PM with Resident 2, Resident^2 stated that they had been seen by a physician and believed their most recent visit was about a month ago for shortness of breath. Resident^2 added that they do not see the facility's physician very often.During a review of LTC SNF Annual History & Physical Note for Resident 2, dated 11/21/2025, the LTC SNF Annual History & Physical Note indicated that this entry constituted a physician encounter for 11/21/2025; however, the completion date, time, and electronic signature could not be verified. This physician encounter occurred 78 days after the previous LTC SNF Monthly Progress Note dated 09/04/2025.During a review of LTC SNF Monthly Progress Note for Resident 2, dated 09/04/2025, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 09/04/2025, and the physician progress note was completed and signed on 09/04/2025 at 9:28 PM. The physician encounter is 142 days after the previous physician LTC SNF Monthly Progress Note dated 04/15/2025.During a review of LTC SNF Monthly Progress Note for Resident 2, dated 03/15/2025, the LTC SNF Monthly Progress Note indicated that this entry constituted a physician encounter for 03/15/2026; however, the completion date, time, and electronic signature could not be verified and the note was marked as a draft. The physician encounter is 90 days after the previous physician LTC SNF Monthly Progress Note dated 12/15/2024.The facility failed to ensure that Resident^2 received physician visits at the required frequency and within the allowable timeframes. Several physician encounters occurred outside the ^70^day window permitted for required visits (including the 10^day grace period). The facility also failed to ensure that physician visit notes were uploaded into Resident^2's electronic health record in a timely manner, limiting clinical staff's ability to review and respond to the resident's ongoing medical needs.During a review of Resident 3's Electronic Medical Record (EHR), the Resident 3's EHR indicated Resident 3 was admitted on [DATE] and has a BIMS Summary Score of 06 as of 05/27/2026. During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 3's EHR was reviewed. The record showed that the last physician progress note was dated 03/03/2026, which was 114 days before the interview. The Medical Records Director confirmed that 03/03/2026 was the most recent physician progress note in Resident^3's EHR.During an interview on 06/25/2026 at 5:05 PM with Resident 3, Resident^3 stated that they have not been seen by a physician at the facility since becoming a resident, but they have seen physicians outside the facility several times.During a review of SNF Custodial 30 Day Visit Note for Resident 3, dated 05/14/2026, the SNF Custodial 30 Day Visit Note indicated that this entry constituted a physician encounter with creation time of 05/14/2026 at 10:54 PM; however, the completion date, time, and electronic signature could not be verified. This physician encounter occurred 72 days after the previous SNF Progress Note dated 03/03/2026.The facility failed to ensure that Resident^3 received physician visits at the required frequency and within the allowable timeframes. Some physician encounters occurred outside the ^70^day window permitted for required visits (including the 10^day grace period). The facility also failed to ensure that physician visit notes were uploaded into Resident^3's electronic health record in a timely manner, limiting clinical staff's ability to review and respond to the resident's ongoing medical needs.During a review of Resident 4's (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronic Medical Record (EHR), the Resident 4's EHR indicated Resident 4 was admitted on [DATE] and has a BIMS Summary Score of 99 as of 04/27/2026, which means Resident 4 was unable to complete the Brief Interview for Mental Status (BIMS).During a concurrent interview and record review on 06/25/2026 at 3:21ˆPM with the Medical Records Director, Residentˆ4's EHR was reviewed and found to contain no physician notes. The Medical Records Director confirmed that none were present. Following a subsequent records request, the facility provided six physician written notes for dates of service 04/18/2025, 10/08/2025, 12/10/2025, 02/11/2026, 04/08/2026, and 06/10/2026. During a review of SNF Custodial 60 Day Visit Note for Resident 4, dated 10/08/2025, the SNF Custodial 60 Day Visit Note indicated that this entry constituted a physician encounter with creation time of 10/08/2025 at 6:04 PM; however, the completion date, time, and electronic signature could not be verified. This physician encounter occurred 173 days after the previous Physician Progress Note dated 04/18/2025.The facility failed to ensure that Residentˆ4 received physician visits at the required frequency and within the allowable timeframes. At least one physician encounter occurred outside the ˆ70ˆday window permitted for required visits (including the 10ˆday grace period). The facility also failed to ensure that physician visit notes were uploaded into Residentˆ4's electronic health record in a timely manner, limiting clinical staff's ability to review and respond to the resident's ongoing medical needs.During a review of Resident 5's Electronic Medical Record (EHR), the Resident 5's EHR indicated Resident 5 was admitted on [DATE] and has a BIMS Summary Score of 13 as of 05/25/2026. During a concurrent interview and record review on 06/25/2026 at 3:21 PM with the Medical Records Director (MRD), Resident 5's EHR was reviewed. The record showed that the last physician progress note was dated 03/16/2026, which was 101 days before the interview. The Medical Records Director confirmed that 03/16/2026 was the most recent physician progress note in Residentˆ5's EHR. Following a subsequent records request, the facility provided eight physician written notes for dates of service 02/04/2026, 02/10/2026, 02/13/2026, 02/19/2026, 03/11/2026, 03/16/2026, 05/15/2026, and 06/18/2026.The facility failed to ensure that physician visit notes were uploaded into Residentˆ5's electronic health record in a timely manner, limiting clinical staff's ability to review and respond to the resident's ongoing medical needs.During a review of the facility's policy and procedure titled Physician Services, dated June 2022, indicates that the policy requires residents to be seen by a physician at least once every 30 days for the first 90 days following admission, and at least once every 60 days thereafter. The policy also states that a physician visit is considered timely if it occurs no later than 10 days after the required due date. Additionally, all physician visits must be conducted personally by the physician.