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	05/08/2026

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate and timely encoding and transmission of resident assessments for 18 of 116 sampled residents. The facility did not encode the Minimum Data Set (MDS, It's a detailed checkˆup form the nursing home fills out to understand what a resident needs and to plan the right care) assessments within the required timeframe and did not ensure successful transmission to the Centers for Medicare & Medicaid Services (CMS) database.This failure to complete and transmit required resident assessment data resulted in incomplete clinical information being available for care planning, increased risk of inaccurate care plans, and potential negative impact on each resident's ability to receive individualized, personˆcentered care.During a concurrent interview and review on 5/6/26 at 2:56 PM with MDS nurse, Resident 71's quarterly MDS with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) of 2/12/26 was reviewed and indicated, the assessment was completed on 2/13/26. However, the assessment was transmitted on 5/5/26, 81 days after the MDS assessment was completed. The MDS nurse confirmed and stated that the assessment was transmitted late due to late completion in some sections of the MDS. Review of facility document titled Final Validation Report for Resident 71, dated 5/5/2026, indicated, Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment. During a concurrent interview and review on 5/7/26 at 1:51 PM with RN 4, Resident 16's quarterly MDS with an ARD21 of 1/31/26 was reviewed and indicated, the assessment was completed on 2/2/26. However, the assessment was transmitted on 4/23/26, 80 days after the MDS assessment was completed. RN 4 confirmed and stated it was late. Review of facility document titled Final Validation Report for Resident 16, dated 5/5/2026, indicated, Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment. During a concurrent interview and record review on 5/06/2026, at 3:54 PM, with MDS Nurse, Resident 28's MDS Quarterly Assessment Reference Date (ARD - It is a specific day that the facility staff looks back from to gather all the patient's medical information) dated 2/20/2026 is still In Progress. During a concurrent interview and record review on 5/06/2026, at 3:58 PM, with MDS Nurse, Resident 94's MDS Quarterly Assessment Reference Date (ARD) dated 2/25/2026 is still In Progress. During a concurrent interview and record review on 5/06/2026, at 4:06 PM, with MDS Nurse, MDS Nurse stated, Resident 151's admission date is 11/19/2022. The 11/19/2025 Annual Assessment for (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

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	05/08/2026

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 151 was completed on 1/25/2026. MDS Nurse's MDS Record review indicated 2/17/2026 Quarterly Assessment is still In Progress. During a review of MDS 3.0 NH Final Validation Report, for Resident 18 indicated, Assessment Completed Late: An OBRA assessment (comprehensive or quarterly) is due every quarter unless the resident is no longer in the facility. A prior record with an ARD (A2300) within 92 days of the submitted record could not be found. During a record review of Quarterly Minimum Data Set (MDS,) dated 12/8/25 for Resident 15, on 5/6/26 at 3:48 PM with MDS nurse, Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed. The MDS indicated, Quarterly due 11/24/25, was completed 12/8/25 and accepted 1/22/26. During an interview on 5/6/26 at 3:38 PM with MDS nurse, MDS nurse stated, Annual Assessment for Resident 15 is due 2/24/26 ARD 3/1/26, shows in progress. It is now May 2026. Resident 15's annual assessment is late and not completed and not submitted. Resident 15 is now due for another quarterly 5/22/26. Per MDS nurse, they have a new MDS nurse to work on these assessments. During a concurrent interview and record review on 05/06/2026 at 4:21 PM with MDS Nurse, and a facility document titled Final Validation Report, dated 4/29/2026 was reviewed, the Validation Report indicated Resident 6 Assessment completed late, MDS Nurse stated Resident 6 is in progress for submission. Quarterly Assessment Reference Date (ARD, a date the nursing home uses to record the resident's condition for the assessment) of Resident 6 was 2/18/2026 and last submission of ARD was on 11/20/2025, while Resident 110 indicated, Assessment Completed late, MDS Nurse further stated, quarterly submission is in progress, Resident 110 quarterly ARD was 2/25/2026 and last submission of Resident 110 quarterly was last 9/1/2025. During review of facility document titled Final Validation Report, dated 4/29/2026, the Validation Report indicated Resident 130 Assessment completed late. A prior record with an ARD within 366 days of the submitted record could not be found, and Resident 14 indicated, Assessment Completed late.A prior record with an ARD within 92 days of the submitted record could not be found. During review of facility document titled Final Validation Report, dated 5/5/2026, the Validation Report indicated, Resident 80 record submitted late: the submission date is more than 14 days.

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	05/08/2026

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS, a resident assessment tool) quarterly assessment was completed at least every 92 days following the previous OBRA (Omnibus Budget Reconciliation Act of 1987) assessment for six of 19 sampled residents (Resident 71, Resident 73, Resident 94, Resident 111, Resident 121, and Resident 16).Failure to complete quarterly resident assessment within the required timeframe could result in delayed identification of needs and significant issues that may affect the physical, mental, and psychosocial well-being of the residents.1. Review of Resident 71's admission record indicated, was admitted to the facility on [DATE].Review of Resident 71's quarterly MDS with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) of 11/14/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 12/17/25, 33 days after the ARD.During concurrent interview and record review on 5/6/26 at 2:56 PM, the MDS nurse reviewed Resident 71's quarterly MDS and stated, the MDS should have been completed and signed on 11/27/25. The MDS nurse also stated that the quarterly MDS assessment should be signed 14 days after the ARD.2. Review of Resident 73's admission record indicated, was readmitted to the facility on [DATE].Review of Resident 73's quarterly MDS with an ARD of 8/28/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 10/30/25, 63 days after the ARD.During a concurrent interview and record review on 5/6/26 at 3:02 PM, the MDS nurse reviewed Resident 73's quarterly MDS and stated, the MDS should have been completed and signed on 9/11/25.3. Review of Resident 94's admission record indicated, was admitted to the facility on [DATE].Review of Resident 94's quarterly MDS with an ARD of 11/25/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 12/15/25, 20 days after the ARD.During concurrent interview and record review on 5/6/26 at 3:07 AM, the MDS nurse reviewed Resident 3's quarterly MDS and stated, the MDS should have been completed and signed on 12/9/25.Review of Resident 94's quarterly MDS with an ARD of 2/25/25 indicated, the status of the assessment indicated in progress.During a concurrent interview on 5/6/26 at 3:08 PM, the MDS nurse stated that in progress means the assessment is not completed.4. Review of Resident 111's admission record indicated, was admitted to the facility on [DATE].Review of Resident 111's quarterly MDS with an ARD of 8/28/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 10/30/25, 63 days after the ARD.During concurrent interview and record review on 5/6/26 at 3:10 AM, the MDS nurse reviewed Resident 111's quarterly MDS and stated, the MDS should have been completed and signed on 9/11/25.Review of Resident 111's quarterly MDS with an ARD of 2/19/26 indicated, the status of the assessment indicated in progress.During a concurrent interview on 5/6/26 at 3:12 PM, the MDS nurse stated that in progress means the assessment is not completed.5. Review of Resident 121's admission record indicated, was admitted to the facility on [DATE].Review of Resident 121's quarterly MDS with an ARD of 8/27/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 10/29/25, 63 days after the ARD.During concurrent interview and record review on 5/6/26 at 3:17 AM, the MDS nurse reviewed Resident 121's quarterly MDS and stated, the MDS should have been completed and signed on 9/10/25.Review of Resident 121's quarterly MDS with an ARD of 2/23/26 indicated, the status of the assessment indicated in progress. During concurrent interview, the MDS nurse stated it should have been completed and submitted on 3/9/26. 6. Review of Resident 16's admission record indicated, was admitted to the facility on [DATE].Review of Resident 16's quarterly MDS with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) of 10/31/25 indicated, the assessment was signed by the RN assessment coordinator as complete on 1/12/26, 73 days after the ARD.Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, (continued on next page)

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	05/08/2026

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored . The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type . The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, SCQA, or Annual assessment + 92 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .

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	05/08/2026

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 - Some	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 and implement personˆcentered care plans for two (2) of 28 sampled residents (Residents 12, 120, and 130) when:Resident 12 did not have a care plan for limited range of motion, despite being ordered Restorative Nursing services (person-centered programs designed to help patients maintain or improve their highest level of physical, mental, and psychosocial independence)Resident 130 received 5 L/min of oxygen instead of the prescribed 2 L/min, contrary to the care plan and physician orders.These deficient practices had the potential to result in unmet care needs, inadequate supervision, and failure to provide services in accordance with physician orders and individualized assessments.2. During initial pool observation on 5/4/2026 at 2:19PM, Resident 130 was noted to be receiving 5 L/min of oxygen. During an interview on 05/06/2026 at 11:41 AM with LVN 2, LVN 2 stated, Resident 130 is using 2 L of oxygen therapy, but sometimes, asked to increase the oxygen because resident 130 tells me it is not enough. When asked to check the current oxygen level, it was noted to be at 4 L. LVN 2 stated, Yes, I know that it should be supervised and checked frequently. Review of Resident 130's care plan indicated the resident oxygen therapy settings at 2 L/min via nasal cannula. Humidified Review with Physician order dated 1/28/2026, the Physician order, indicated, Oxygen inhalation via nasal cannula for COPD. During a review of Facility's Policy and procedure titled, Oxygen administration, delivery device dated August 2017, indicated, Guidelines: 1. The nasal cannula (low concentration) .the nasal cannula may deliver as much as 40% oxygen (at 5lpm. Excessive flow rates are to be avoided as they will not significantly increase Fio2 (The amount of oxygen a person is breathing in) and may cause considerable pain in the frontal sinuses (The hollow spaces in the forehead). 1. Review of Resident 12's admission record indicated, was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI, a bacterial infection of the urinary system, including the bladder, urethra, or kidneys), gram-negative sepsis (a life-threatening medical emergency triggered when a Gram-negative bacterial infection enters the bloodstream and causes an extreme, body-wide inflammatory response), polyneuropathy (simultaneous damage to multiple peripheral nerves throughout the body), muscle weakness, pressure ulcer of right heel, and other abnormalities of gait and mobility. Review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 4/9/24 indicated moderate cognitive (thought process) impairment. Under the functional abilities section indicated, Resident 12 has impairment on bilateral upper extremities, dependent and required two or more helpers (persons) with walking and chair/bed-to-chair transfer. During an observation on 5/4/26 at 3:03 PM in resident's room, Resident 12 was in bed awake and having a conversation with the son at the bedside. During a concurrent interview, the son stated that Resident 12 was not receiving physical therapy and usually stays in bed. (continued on next page)

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	05/08/2026

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 - Some	During a concurrent interview and record review on 5/8/26 at 10:44 AM with Registered Nurse (RN) 2, Resident 12's active orders for May 2026 was reviewed. The active orders indicated the following were ordered on 3/24/26: RNA (Restorative Nursing Assistant, an enhanced Certified Nursing Assistant (CNA) who specializes in helping patients maintain or regain their mobility, strength, and independence) for ambulation with front wheeled walker three times a week (3x/week) or as tolerated to maintain functional mobility. RNA for AROM (active range of motion) to left lower extremity (LLE) 3x/week or as tolerated to maintain function and strength, maintain ROM, to decrease risk of contractures. RNA for AROM to left upper extremity (LUE) 3x/week or as tolerated to maintain ROM, to decrease risk of contractures. RNA for AROM to right lower extremity (RLE) 3x/week or as tolerated to maintain ROM, to decrease risk of contractures. RNA for AROM to right upper extremity (RUE) 3x/week or as tolerated to maintain ROM, to decrease risk of contractures. RNA for bed mobility & transfers 3x/week or as tolerated to maintain functional mobility. Sit to stand 3x/week or as tolerated to maintain functional mobility. During a concurrent interview, RN 2 stated that Resident 12 had been discharged from therapy and placed on the Restorative Nursing Assistance (RNA) program on 3/25/26. RN 2 also reported that Resident 12 was consistently bedbound. During further record review and a concurrent interview with RN 2 on 5/8/26 at 10:48 PM, the care plan was reviewed and it was noted that the orders for the RNA program were not addressed. RN 2 confirmed the omission and stated there was no care plan outlining Resident 12's limited range of motion or the physicianˆordered RNA services. RN 2 acknowledged, there should be a care plan. Review of the facility's policy and procedure titled, Standards for Restorative Nursing Program, released September 2019, indicated, Restorative Nursing program is a service provided by the facility generally under nursing, to ensure maintenance of a patient's optimum level of function. The patients on this program are encouraged or assisted to achieve and maintain their highest level of self-care and independence . Documentation: .3. The specific treatment provided as outlined in the care plan will be initialed daily, or as specified by the plan, by the RNA.

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	05/08/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prescription medications and biologicals were labeled and stored according to manufacturer's instructions and facility policy and procedures, as evidenced by the following:A bottle of Dabigatran etexilate (a prescription oral blood thinner) capsule and one vial of multi-dose Heparin Sodium 5,000 unit/mL (a fast-acting injectable anticoagulant used to prevent blood clots) were opened and undated.Residents and staff personal items such as pouch, jewelry, hearing aid, dentures, cellphones, cellphone charger, eyeglasses, and iPad were stored in the controlled medication compartment of Medication Carts #4 & #1.Two vials of Tubersol (Tuberculin Purified Protein Derivative-a sterile, standardized solution used primarily for Mantoux tuberculin skin testing) in the refrigerator in Station 1 medication storage room were opened and undated.These failures increased the risk of administering expired, contaminated, or improperly stored medications, which could lead to ineffective treatment or resident harm.During an inspection of Medication Cart #4 on [DATE] at 11:08 AM with Licensed Vocational Nurse (LVN) 1, a bottle of Dabigatran etexilate capsule and a vial of multi-dose Heparin sodium were found in the top drawer without open or use by dates.During a concurrent interview with LVN 1 on [DATE] at 11:08 AM, LVN 1 confirmed both medications were opened and undated, stating Heparin should be discarded after 28 days, while Dabigatran follows the manufacturer's expiration date.According to the manufacturer's package insert for Dabigatran etexilate, .Once opened, the product must be used within 4 months. Keep the bottle tightly closed. Store in the original package to protect from moisture.According to the manufacturer's package insert for Heparin sodium, .Multiple-dose vials: Once punctured, the vial should be dated and the unused portion discarded within 28 days.During further inspection of Medication Cart #4 with LVN 1on [DATE] at 11:15 AM, the following items were observed:Personal items including a black pouch, a necklace in a blue jewelry container, a hearing aid, and a cellphone were stored in the controlled medication compartment.A foreign currency (500 pesos) was kept on the top drawer alongside opened bottles of over the counter oral medications, injections, and suppositories.A printed red pouch was found in the bottom drawer alongside oral medications.During a concurrent interview on [DATE] at 11:15 AM, LVN 1 confirmed that the items in the controlled medication compartment were residents' valuables, and the printed red pouch had her own personal belongings. LVN 1 also stated that the foreign currency was kept in the medication drawer as good luck.During an inspection of Medication Cart #1 on [DATE] at 11:41 AM with Registered Nurse (RN) 3, it was observed that personal items including iPad, hearing aids, eyeglasses, dentures, batteries, and cellphone charger were stored in the controlled medication compartment. During a concurrent interview, RN 3 confirmed that the items in the controlled medication compartment were residents' valuables.During an inspection of the medication storage room in Station 1 on [DATE] at 11:58 AM with RN 3, two vials of Tubersol solution were stored in the refrigerator without an open or use by dates. During a concurrent interview, RN 3 stated that the solution should be discarded 28 days after opening.During an interview on [DATE] at 12:16 PM, the Director of Nursing (DON) stated that personal belongings should not be kept in the medication cart because of concerns about infection control and the risk of drug diversion.Review of the facility's policy and procedures titled, Storage of Medication, dated 09/2018, indicated, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff member lawfully authorized to administer medications .

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	05/08/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse involving Resident 160 to the State Survey Agency, as required by facility policy and federal regulations.Failure to promptly report allegations of abuse had the potential to place residents at risk for unaddressed harm and compromise the facility's duty to protect residents' health, safety, and rights.Review of Resident 160's admission record indicated, was admitted to the facility on [DATE] with diagnoses that included a heart attack, a urinary tract infection, type 2 diabetes (high blood sugar), left lower leg closed fracture, and Alzheimer's disease (memory loss and confusion).Review of the Minimum Data Set (MDS) dated [DATE] indicated the Resident 160's cognition was moderately impaired.During a concurrent interview and record review on 5/8/26 at 1:29 PM, the Registered Nurse Supervisor (RNS) reviewed Resident 160's progress notes titled Nurses Notes. The entry dated 3/15/26 at 3:15 PM indicated the resident was discharged home with the daughter on 3/15/26 at 2:40 PM.During further review of the Nurses Notes dated 3/15/26 at 2:42 PM indicated, Upon discharge, daughter [Name] brought up a concern and asked the writer to asked her mom directly on what happened. Per resident, an incident happened between Monday 3/9 - Thursday 3/12 where two workers came to her room to clean her and one of the workers stuck his finger inside her rectum so hard that she screamed. Resident stated that it hurt very bad and she was in pain. When he pulled his finger out, he showed it to her and stated, you have a lot of poop, then resident told him not to touch her again. Per resident, this happened in the evening. The concern was brought up to the DSD (Directo of Staff Development) and daughter was assured that we will do a follow up on the incident.During the same interview on 5/8/26 at 1:29 PM, the RNS stated the Nurses Notes documented an allegation that required immediate reporting to the Ombudsman and the State Survey Agency. The RNS was unable to locate documentation that the allegation had been reported or investigated.During an interview on 5/8/26 at 1:50 PM, the Administrator stated they were not aware of the allegation and confirmed that the incident should have been reported, regardless of the resident's discharge.Review of the facility's policy and procedures titled, Abuse and Neglect Prohibition Policy, dated 06/2022, indicated, .F. Reporting of Incidents, investigations and facility's response to the investigation: 1.Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or exploitation the Administrator or designee will perform the following: i. All alleged violations-Immediately but not later than: 1. 2 hours - if the alleged violation involves abuse or results in serious bodily injury. 2. 24 hours-if the alleged violation does not involve abuse and does not result in serious bodily injury. ii. Report the incident to the local Ombudsman or the local law enforcement agency by telephone as soon as possible, and; iii. Submit written report to the local Ombudsman or the local law enforcement agency using the California Report of Suspected Dependent Adult/Elder Abuse Form (SOC 341) . iv. The Licensing and Certification Program Distric Office is required to receive these reports .

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	05/08/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of abuse involving Resident 160.This failure had the potential to place residents at risk for unaddressed harm and compromised the facility's duty to protect residents' health and safety.Review of Resident 160's admission record indicated, was admitted to the facility on [DATE] with diagnoses that included a heart attack, a urinary tract infection, type 2 diabetes (high blood sugar), left lower leg closed fracture, and Alzheimer's disease (memory loss and confusion).Review of the Minimum Data Set (MDS) dated [DATE] indicated the Resident 160's cognition was moderately impaired.During a concurrent interview and record review on 5/8/26 at 1:29 PM, the Registered Nurse Supervisor (RNS) reviewed Resident 160's progress notes titled Nurses Notes. The entry dated 3/15/26 at 3:15 PM indicated the resident was discharged home with the daughter on 3/15/26 at 2:40 PM.Further review of the Nurses Notes dated 3/15/26 at 2:42 PM indicated, Upon discharge, daughter [Name] brought up a concern and asked the writer to asked her mom directly on what happened. Per resident, an incident happened between Monday 3/9 - Thursday 3/12 where two workers came to her room to clean her and one of the workers stuck his finger inside her rectum so hard that she screamed. Resident stated that it hurt very bad and she was in pain. When he pulled his finger out, he showed it to her and stated, you have a lot of poop, then resident told him not to touch her again. Per resident, this happened in the evening. The concern was brought up to the DSD (Directo of Staff Development) and daughter was assured that we will do a follow up on the incident.During a concurrent interview on 5/8/26 at 1:29 PM, the Registered Nurse Supervisor (RNS) stated the Nurses Notes documented an allegation that required immediate reporting and investigation. The RNS was unable to locate documentation showing the allegation was reported or investigated, as required.During an interview on 5/8/26 at 1:50 PM, the Administrator stated they were not aware of the allegation and confirmed that the alleged incident was not investigated.Review of the facility's policy and procedures titled, Abuse and Neglect Prohibition Policy, dated 06/2022, indicated, .F. Reporting of Incidents, investigations and facility's response to the investigation: 1.Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or exploitation the Administrator or designee will perform the following: i. All alleged violations-Immediately but not later than: 1. 2 hours - if the alleged violation involves abuse or results in serious bodily injury. 2. 24 hours-if the alleged violation does not involve abuse and does not result in serious bodily injury. ii. Report the incident to the local Ombudsman or the local law enforcement agency by telephone as soon as possible, and; iii. Submit written report to the local Ombudsman or the local law enforcement agency using the California Report of Suspected Dependent Adult/Elder Abuse Form (SOC 341) . iv. The Licensing and Certification Program Distric Office is required to receive these reports .

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	05/08/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure proper notification when residents are discharged , when one of three residents, Resident 158 went home, Ombudsman was not notified. This failure could put a resident with no protection and an advocate to inform them of options and rights with regards to discharge.Findings:During a review of Resident 158's admission Record, dated 5/8/26, indicated, admitted [DATE] with diagnoses including Cellulitis(infection of wound) of back, Depression (a health condition with feeling of sadness, low energy). During a concurrent interview and record review on 5/7/26 at 11 AM, with RN 1, per RN 1, resident is alert and oriented x 4. Went out of facility on 2/2/26, did not return, did not sign Out On Pass (OOP) form. Staff calling patient and son but not answering. On 2/3/26, no call and not returned yet till 2/3/26 at 11 AM, resident came back to gather her belongings and does not want to stay. Per patient, she went to her friend's house, fell asleep coz she cannot sleep at the noise in the facility. SW and nurse trying to let her stay for wound care needs, patient decided to leave against medical advise (AMA). Police was called before patient came back. Patient signed AMA form, understand the consequence of no Home Health follow up. Asked RN1 for the discharge notification, no notification sent to Ombudsman. RN1stated, there is specific form for Ombudsman notification. RN1 unable to find form. During a review of Resident 158's Against Medical Advise (AMA) form, dated 2/3/26, the AMA form indicated resident certify leaving the facility Against Medical Advise. During a review of Physician's Progress Notes, dated 2/4/26, indicated, the progress notes indicated, resident was admitted for long term care after completion of rehab services and IV (intravenous) antibiotics and wound care. IV antibiotics completed on 1/25/26 and was switched to oral doxycycline for 3-6 months. Wound care no new skin issues noted .Homelessness, social work consult. Follow up with PCP(primary care physician), [NAME] ID(Infectious Doctor) clinic and neurosurgery clinic. 2/2/26 left without OOP (out on pass). 2/3/26 patient decides to leave against medical advise. Tried to get patient to stay, about sending Doxycycline, but patient is signed out against medical advise and wants to leave asap . During a review of facility's Policy and Procedure titled, Transfer and Discharge, dated 12/16, indicated, Purpose: The transfer and discharge process must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the facility. Procedure: 4. At least 30 days prior to transfer or discharge, notify the resident, and if known the family member, surrogate, or resident representative of the transfer and the reason for the move. c. Provide the name, address, and phone number of: the state long term care ombudsman.

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	05/08/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the annual Minimum Data Set (MDS, a resident assessment tool) was completed within the required period of 14 calendar days of Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) for two of 19 sampled residents (Resident 73 and Resident 111).Failure to complete a comprehensive resident assessment within the required timeframe could result in delayed identification of needs and significant issues that may affect the physical, mental, and psychosocial well-being of Resident 73 and Resident 111.1. Review of Resident 73's admission record indicated, was admitted to the facility on [DATE].Review of Resident 73's annual MDS assessment with an ARD of 2/11/26, indicated, the assessment was signed by the Registered Nurse (RN) assessment coordinator as complete on 5/5/26, 83 days after the ARD. During a concurrent record review and interview on 5/6/26 at 3:06 PM, the MDS nurse reviewed Resident 73's annual MDS assessment with an ARD of 2/11/26 and confirmed the MDS was completed late. The MDS nurse stated that Resident 73's annual MDS assessment should have been completed and signed on 2/25/26.2. Review of Resident 111's admission record indicated, was admitted to the facility on [DATE].Review of Resident 111's annual MDS assessment with an ARD of 11/28/25, indicated, the assessment was signed by the Registered Nurse (RN) assessment coordinator as complete on 12/24/25, 26 days after the ARD. During concurrent interview and record review on 5/6/26 at 3:12 AM, the MDS nurse reviewed Resident 111's quarterly MDS and stated, the MDS should have been completed and signed on 12/12/25.According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, dated October 2024, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates . The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .

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	05/08/2026

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA, is a comprehensive assessment for a resident that must be completed when the IDT (interdisciplinary team, a collaborative group of professionals from diverse fields who work together interdependently to achieve shared goals) has determined that a resident meets the significant change guidelines for either major improvement or decline) for one of 19 sampled residents (Resident 73) who was admitted to hospice care on 11/5/25.This failure could potentially delay the provision of appropriate treatment and services for Resident 73.Review of Resident 73's admission record indicated, was admitted to hospice on 11/5/25 with diagnoses including heart failure, high blood pressure, and dementia (a group of symptoms affecting memory, thinking and social abilities).Review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) 11/12/25, indicated, a SCSA was completed when Resident 73 was enrolled to hospice care.11/12/25 Significant Change in Status MDS for Hospice - completed 1/24/26 (supposed to be completed on 11/25/25During concurrent interview and record review on 5/6/26 at 3:02 PM, MDS nurse stated that residents placed on hospice will need a significant change in status assessment and should be completed 14 days from the day resident was admitted to hospice. During concurrent record review, Resident 73's SCSA MDS was signed by the RN assessment coordinator as complete on 1/24/26, 81 days after Resident 73 was admitted to hospice. Additionally, the MDS nurse stated that it should have been completed on 11/25/25.Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than) . The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met .

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	05/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility did not collaborate with Hospice the plan of care for two out of five residents (Residents 27and 16)This failure could result to residents not receiving care as planned.During a review of Resident 27's admission Record, dated 5/6/26, the admission record indicated, admitted on [DATE] with diagnoses including: Alzheimer's Disease(a progressive, irreversible brain disorder that destroys memory and thinking), Osteoarthritis of Knees(a common form of arthritis). During an observation on 5/5/26 at 11 AM, observed resident up on wheelchair, smiling, not responding to questions. During an interview on 5/5/26 at 11 AM with Certified Nursing Assistant (CNA) 4, stated, she has been her permanent CNA for many years. Since after her fall, she is now in wheelchair, can still walk to the bathroom with assistance. She is now under Hospice Care since last month. She had no changes, eats with good appetite, 100 % of meals, no skin breaks. She has family but only came when she was signed up for Hospice. I see hospice nurse and CNA come here per CNA. During a review of Physician's order, dated May 2026, the Physician's order indicated Palliative Care ordered 4/22/26. Hospice under Sutter Health with diagnosis of Cerebral Atherosclerosis. During a concurrent interview and chart review on 5/7/26 at 2PM with Registered Nurse (RN)1, care plan for Resident 27 was reviewed. The care plan indicated, Sutter Hospice 5/6/26. RN1 stated, resident is admitted to Hospice on 4/22/26 as Physician ordered. RN 1stated, care plan should focus on pain management and comfort and should be in collaboration with Hospice agency. Hospice agency information not in the care plan, facility team member contact person not in the care plan. Per RN1, each Hospice agency has a binder for each Hospice patient that their staff document on when they visit. During a review of facility's policy and procedure (P&P) tilted, Hospice Care, dated 8/17, the P&P indicated, When a facility resident elects to provide hospice care, the facility staff communicates with the hospice agency to establish and agree upon a coordinated plan of care that is based on an assessment of the resident's needs and living situation in the facility. Guidelines: 2. Develop a plan of care that reflects the participation of the hospice agency, the facility, and the resident and family to the extent possible. 3. Ensure that the plan of car identifies the car and services which the facility and hospice agency will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care. Review of Resident 16' admission record indicated, was admitted to hospice care on 3/29/26 with a diagnosis of cerebrovascular accident (CVA, commonly known as a stroke). During concurrent record review and interview with RN 3 on 5/7/26 at 1:51 PM, Resident 16's plan of care was reviewed and indicated there was no hospice care plan developed in collaboration with the Hospice agency. Additionally, there was no hospice information in Resident 16's electronic health record for facility staff to refer to. RN 3 stated, I don't see one.

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	05/08/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their smoking policy and procedures (P&P) when it allowed two of eight residents (Resident 4 and Resident 81) who smoked in the facility to keep possession of their own lighters and cigarettes inside the resident care area.This failure posed an increased risk for combustion and/or fire, resulting in the potential for serious injury and/or death to residents, staff, and visitors.During an interview on 05/06/2026, at 12:20 PM, at Resident 4's room with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, the orange plastic tube with liquid inside found on the overbed table beside the resident's bed is a disposable cigarette lighter used by Resident 4 for smoking. LVN 2 further stated, there is a smoking schedule, but Resident 4 does not follow it. LVN 2 stated, Resident 4 keeps his cigarette in his room. LVN 2 is not sure about the facility's policy regarding safekeeping of cigarettes and lighters and if Resident 4 was educated about smoking and the use of lighters. During an interview on 05/06/2026, at 12:30 PM, at Resident 4's room with Certified Nursing Assistant (CNA) 2, CNA 2 is assigned to Resident 4 three times a week. CNA 2 stated, Resident 4 goes out by wheelchair, to the front of the facility to smoke. CNA 2 further stated, cigarettes and lighters are supposed to be kept in the nurses' station, but Resident 4 is keeping it with him and not inform staff when he wants to smoke. Resident 4 does not follow the policy and becomes agitated when reminded about the policy. Resident is independent and ambulates using his wheelchair without assistance. During an observation on 05/07/2026 at 1:54 PM, Surveyor went back to Resident 4's room to speak with the resident, but resident was sleeping. While in Resident 4's room, Surveyor saw two disposable cigarette lighters on the overbed table of the resident, the same place where the first disposable cigarette lighter was seen on 05/06/2026 at 12:12 PM. During an interview on 05/06/2026, at the facility's Conference Room with RN 1, RN 1 stated, cigarette lighters for smokers should always be kept at the nurse's station. During a review of the facility's Smoking Policy-Residents, dated 06/22/2022, the Smoking Policy-Residents indicated 12. Smoking articles for residents with independent smoking privileges: b. Residents may not keep even disposable lighters. All other forms of lighters, including matches, shall be prohibited. During a review of Resident 4's Care Plan Report, dated 10/16/2024, the Care Plan Report indicated, the lighter should be kept by the nursing station. During a review of Resident 4's Care Plan Report, dated 03/05/2026, the Care Plan Report indicated, 3. Educate resident of smoking policy and safety hazard. 6. Keep smoking paraphernalia secured at all times. Review of Resident 38's admission record indicated, was admitted to the facility on [DATE] with diagnoses including dementia (a group of symptoms affecting memory, thinking and social abilities) with other behavioral disturbance, nicotine dependence, high blood sugar, and high blood pressure. Review of Resident 33's Minimum Data Set (MDS) assessment dated [DATE] indicated in the Staff (continued on next page)

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	05/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment for Mental Status section that Resident 38 has a memory problem and demonstrated modified independence—some difficulty in new situations only when it comes to Cognitive Skills for Daily Decision Making. During an observation on 5/4/26 at 2:10 PM, in resident's room, Resident 38 was seen sitting and smoking on the patio outside his room. Resident 38 had two lighters, three cigarette packs, and a glass container holding dried, greenish leaves. During an interview on 5/4/26 at 2:12 PM, Resident 38 stated that he keeps his own smoking paraphernalia. During concurrent record review and interview with the MDS nurse on 5/6/26 at 3:26 PM, Resident 38's Smoking Assessment indicated resident was a safe, independent smoker. The MDS nurse stated that, per facility policy, lighters are not allowed at the bedside. Resident 38 received education and a copy of the smoking policy and demonstrated understanding. Review of Resident 38's smoking care plan revised on 9/4/25 indicated, .the lighter should be kept by the nursing station.

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	05/08/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care and services were provided as required for two of six sampled residents (Resident 130 and Resident 4). The facility did not provide appropriate supervision during the residents' nebulizer treatments (A nebulizer treatment is a process in which a machine turns liquid medication into a mist that the resident breathes in through a mask or mouthpiece to help improve breathing).This failure resulted in the residents not receiving respiratory treatment in accordance with the facility's policy, procedure, and individualized care plans, placing the residents at risk for unmet respiratory needs. During an observation on 5/4/2026 at 2:30 PM at Resident 130 room, Resident 130 was found sleeping with the nebulizer tubing on the resident's chest. The nebulizer machine was on the bed beside the resident, and the machine was still on. During a concurrent interview and observation on 5/4/2026 at 2:32PM in front of room [ROOM NUMBER], with License Vocational Nurse (LVN) 3, LVN3, stated, The Resident 130 wants to do it on his own. We don't wait until he finishes his nebulizer treatment. We just remind the resident to turn off the machine because he always forgets it. LVN 3, was observed giving the respiratory medication to Resident 130 and then leaving the resident unattended during the treatment. During an interview on 05/6/2026 at 11:41 AM with License Vocational Nurse, (LVN) 2, LVN2 stated, Its a routine that's why its always on the residents bedside, Resident 130 don't it want to removed. the resident does that all the time, turn it without the medication, the room mate comes to tell me that the machine is on. Review of resident 130's admission record, dated 5/7/2026, the admission record indicated, resident 130 was admitted [DATE], with active diagnosis of chronic respiratory failure with hypoxia (person's lungs are not able to get enough oxygen into their body over a long period of time), chronic obstructive pulmonary disease (COPD) (a person has longˆterm lung damage that makes it hard to breathe). A review of Physicians order dated 1/26/2026, the physician order Resident 130, indicated, 1. Albuterol Sulfate 3ml inhale orally via nebulizer every 6 hours for SOB while awake 2. AR formoterol Tartrate Inhalation Nebulizer 2ml inhale orally via nebulizer two times a day for short of breath (SOB) 3. Budesonide inhalation Suspension 0.5mg/2ml. 1 application inhale orally two times a day for COPD via nebulizer. Rinse mouth with water and spit back into cup after use. During Record review of resident care plan on nebulizer dated 5/7/2026, the care plan indicated, Educated resident regarding safety hazards and infection control concerns associated with keeping nebulizer machine on bed. Encouraged resident to store nebulizer equipment in designated safe area after treatments. During a review of facility's Policy and Procedure titled Aerosolized Medication (Neb Med) dated August 2017, indicated, Procedure .8. assess the resident .b. check respiratory rate prior to treatment. 10 .Encourage and work with the resident throughout the treatment for use of the proper and most (continued on next page)

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	05/08/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effective technique. 11. Continue to monitor resident throughout treatment .17. Rinse the nebulizer and mouthpiece. Shake to air dry and store in a plastic bag that is labeled with the resident's name and room number. During initial tour on 5/04/2026 at 2:15 PM, Resident 4 is awake, sitting on the left side of bed, nebulizer was on; the resident holding the breathing mask near the nose and mouth but elastic straps were not secured on the resident's ears. Resident 4 was nebulizing, no staff present in the room, turned off the nebulizer on his own. During a follow-up visit on 5/06/2026 at 12:12 PM, at Resident 4's room, resident was sleeping in bed, nebulizer machine was on the left side of bed. During an interview on 5/06/2026 at 12:20 PM at resident 4's room, with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, Resident 4 needs to nebulize for shortness of breath due to Chronic Obstructive Pulmonary Disease (COPD), (a progressive, long-term disease that makes it difficult to breathe by causing inflammation, damage, and obstruction in the airways). LVN 2 further stated, the resident needs supervision by assigned Licensed Nurse until nebulizing is done. The schedule to nebulize on morning shift is every 9:00 AM but not sure of the exact time on PM shift. During an interview on 5/06/2026 at 12:30 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated, LVN knows when resident needs to nebulize. CNA 2 further stated, Resident 4 becomes agitated when he needs medication and nebulizer treatment. During record review of Physician's Order dated 1/02/2026 indicated Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML-inhale orally via nebulizer every 4 hours as needed for shortness of breath (SOB)/wheezing.

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	05/08/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement its infection control program when:Certified Nursing Assistant (CNA) 4 did not perform hand hygiene when handling soiled linens and entering resident rooms.Residents and staff personal items such as pouch, jewelry, hearing aid, dentures, cellphones, phone charger, eyeglasses, and iPad were stored in the controlled medication compartment of the medication cart.Foreign currency was kept in the top drawer of the Medication Cart #4, alongside opened bottles of over the counter oral medications, epinephrine injections (the primary emergency treatment for severe allergic reactions), and suppositories (medications administered through the rectum, vagina, or urethra).These failures had the potential for crossˆcontamination of infection that can compromise the health and safety of residents and staff.1. During an observation on 5/4/26 at 2:54 PM in the hallway, CNA 4 was seen exiting a resident's room that had an Enhanced Barrier Precaution (are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) sign posted by the door. CNA 4 was wearing a surgical mask and gloves while carrying a transparent bag containing soiled linens. CNA 4 discarded the bag into a soiledˆlinen hamper, removed gloves, and did not perform hand hygiene before re-entering the resident room.During a follow-up interview on 5/4/26 at 2:57 PM, CNA 4 acknowledged forgetting to perform hand hygiene after handling soiled linens. CNA 4 stated that hand hygiene is required before and after handling soiled linens, and when entering or exiting a resident's room.During an interview on 5/8/26 at 2:20 PM, the Infection Preventionist (IP) stated that staff are required to practice hand hygiene both before and after delivering care to residents, when handling soiled linens, and donning (putting on) and doffing (taking off) personal protective equipment (PPE- which refers to equipment used to reduce exposure to hazards that could lead to serious workplace injuries or illnesses).Review of the facility's policy and procedure titled, Hand Hygiene, released 08/2017, indicated, All staff having direct resident contact will use appropriate hand hygiene . 1. All employees having direct resident contact will sanitize their hands at least under the following situations: . c. Before and after any physical contact with resident equipment or personal articles that are likely to be contaminated with bodily secretions . i. After removing gloves. 2. During an inspection of Medication Cart #4 on 5/6/26 at 11:08 AM with Licensed Vocational Nurse (LVN) 1, it was observed that personal items including a black pouch, a necklace in a blue jewelry container, a hearing aid, and a cellphone were stored in the controlled medication compartment. Additionally, a printed red pouch was found in the bottom drawer alongside oral medications. During a concurrent interview, LVN 1 confirmed that the items in the controlled medication compartment were residents' valuables, and the printed red pouch contained her own personal belongings.During an inspection of Medication Cart #1 on 5/6/26 at 11:41 AM with Registered Nurse (RN) 3, it was observed that personal items including iPad, hearing aids, eyeglasses, dentures, batteries, and cellphone charger were stored in the controlled medication compartment. During a concurrent interview, RN 3 confirmed that the items in the controlled medication compartment were residents' valuables.During an interview on 5/6/26 at 12:16 PM, the Director of Nursing (DON) stated that personal belongings should not be kept in the medication cart because of concerns about infection control and the risk of drug diversion.Review of the facility's policy and procedures titled, Storage of Medication, dated 09/2018, indicated, .The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff member lawfully authorized to administer medications .