STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056271	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and medical record review, the facility failed to ensure complete and accurate medical records for two of four sampled residents (Residents 2 and 3). * Resident 2's neurological assessments were incomplete, and the resident's IDT Note was completed three days after the IDT meeting was conducted. * Resident 3's Physician Progress Note was dated as completed one week after the resident had been transferred to the acute care hospital and was no longer in the facility. These failures resulted in medical records that contained incomplete or inaccurate information, which could negatively affect continuity of care.Findings: 1. Closed medical record review for Resident 3 was initiated on 5/15/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's SBAR Communication Form dated 5/6/26, showed the resident was found on the floor in the resident's room, complained of head pain, and 911 was called. Review of the facility's midnight Daily Census for 5/14/26, showed Resident 3 was not currently in the facility. The census's Hospital Tracking section listed seven residents currently hospitalized , including Resident 3 with a transfer date of 5/6/26. a. Review of Resident 3's Transfer Out to Hospital Note dated 5/6/26 at 0042 hours, showed the resident was transferred out to the acute care hospital due to a fall. Review of Resident 3's Physician Progress Note dated 5/13/26 at 2247 hours, showed the resident was assessed by the PA. On 5/15/26 at 1233 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON reviewed Resident 3's Physician Progress Note dated 5/13/26, and verified the documentation was inaccurate since the resident was not in the facility at that time. b. On 5/15/26 at 0820 hours, the DON was asked to provide a list of the seven residents listed on the census's hospital tracking list and their reasons for transfer. Review of the list provided by the DON showed Resident 3 was one of two residents transferred after a sustaining a fall at the facility. On 5/15/26 at 0928 hours, Resident 3's closed hard chart medical record was requested. On 5/15/26 at 0931 hours, access to the facility's EHR was provided.Review of Resident 3's N Adv - Post Fall Evaluation dated 5/6/26 at 0700 hours, showed the evaluation was documented as a late entry and created on 5/15/26 at 0946 hours. On 5/15/26 at 1233 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated post fall evaluations should be initiated as soon as possible after a fall, no later than the end of the shift, completed within 72 hours. The DON stated he conducted Resident 3's post fall evaluation on the morning of 5/5/26, but did not document it in the resident's HER until 5/15/26. The DON verified the evaluation was created and completed late. 2. Medical record review for Resident 2 was initiated on 5/15/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 3's SBAR Communication Form dated 5/10/26, showed at 0400 hours the staff heard the resident's bed alarm and found the resident sliding down the bed onto the floor mat. The form showed primary care clinician was notified and recommended neurological monitoring for 72 hours. a. Review of Resident 2's Neurological Assessment flowsheet initiated 5/10/26, showed neurological assessments were to be completed at a scheduled frequency of every 15 minutes for four assessments, every 30 minutes for four assessments, every hour for four hours, every four hours for four assessments, and then every shift (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
	056271	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	for six assessments. The form showed all scheduled assessments were completed; however, the last documented assessment was completed on 5/12/26 for the 1500-2300 hours shift. The flowsheet did not show neurological assessments were completed through the full 72-hour period ending 5/13/26 at 0400 hours. On 5/15/26 at 1619 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the neurological assessments were not conducted for the full 72 hours. b. Review of Resident 3's IDT note dated 5/12/26, showed it was a late entry, created on 5/15/26 at 0813 hours; three days after the IDT meeting. The note showed the IDT met with the resident's daughter to review fall risk factors, the resident's status, plan of care and fall prevention Interventions. On 5/15/26 at 1601 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the IDT note was not completed timely and stated he did not know why it was documented on 5/15/26, by the MDS Nurse who was not working today.