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	02/07/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 20 final sampled residents (Resident 389) was safe to self-administer the medications found at the bedside. * The facility failed to ensure the bottles of ibuprofen (NSAIDs), and Advil (NSAIDs), several tablets of alpha-chymotrypsin (a digestive enzyme supplement), a tube of arthritis relief pain ointment (NSAIDs), and a bottle of dry relief eye drops (used to relieve irritation and discomfort caused by dry eyes) were not at Resident 389's bedside table. Resident 389 stated she administered the medications herself, however, Resident 389 was not assessed for safe self-administration of medications per her admission assessment. This failure had the potential for Resident 389 to administer the medications inaccurately, the risk of adverse reactions from the medications, and negatively affect Resident 389's well-being. Findings: Review of the facility's P&P titled Medication - Self-Administration revised 12/2016 showed the following: - For self-administering residents, the nursing staff member will determine who will be responsible (the resident or the nursing staff member for documenting that medications were taken; - Self-administered medications must be stored in a safe and secured place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them; and - Staff member shall identify and give to the charge nurse any medication found at the bedside that are not authorized for self-administration, for return to the resident's family or responsible party. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 1355 hours, during the initial tour of the facility, Resident 389 was observed lying in bed. A bottle with foreign language characters and a handwritten note on the bottle showed ibuprofen 400 mg, a bottle of Advil 200 mg, a bottle of dry eye relief eyedrop, blister packs of alpha-chymotrypsin, and a tube of arthritis relief pain ointment were observed on the bedside table. Resident 389 stated she administered the ibuprofen and Advil medications for headache, the alpha-chymotrypsin medication for her stomach, the ointment for her right knee and the eyedrops for her eyes. On 2/4/25 at 1400 hours, an observation for Resident 389 and concurrent interview was conducted with LVN 2. Resident 389 observed lying in bed. A bottle with foreign language characters and a handwritten note on the bottle showed ibuprofen 400 mg, a bottle of Advil 200 mg, a bottle of dry eye relief eyedrop, blister packs of alpha-chymotrypsin, and a tube of arthritis relief pain ointment were observed on the bedside table. LVN 2 verified the above findings. LVN 2 stated the residents were not allowed to have medications at the bedside, and Resident 389 could not take medications by herself. Medical record review for Resident 389 was initiated on 2/4/25. Resident 389 was admitted to the facility on [DATE]. Review of Resident 389's MDS dated [DATE], showed Resident 389 had a moderate cognitive impairment, and impairment on both upper extremities. Review of Resident 389's Admission/ Readmission Screen and Baseline Plan 4.1 dated 1/18/25, showed Resident 389 did not request to self-administer her medications. Review of Resident 389's Order Summary Report dated 2/5/25, did not show the physician's orders to administer the ibuprofen, Advil, eyedrops, alpha-chymotrypsin, and arthritis relief pain ointment medications. On 2/5/25 at 1535 hours, an interview and concurrent medical record review for Resident 389 was conducted with RN 3. RN 3 verified the above findings. RN 3 stated the residents were assessed upon admission whether they wanted to and could self-administer any medications. RN 3 stated if a resident wanted to self-administer a medication, then a full assessment would be conducted to determine whether the resident could self-administer the medications safely. RN 3 verified Resident 389 did not have the physician's orders to administer the ibuprofen, Advil, eyedrops, alpha-chymotrypsin, and arthritis relief pain ointment medications, and to self-administer any medications. RN 3 verified Resident 389 was not assessed if she was safe to self-administer the medications.

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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** 50787 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for two of three final sampled residents (Residents 7 and 685) reviewed for falls. * The facility failed to ensure Resident 685's post fall neurological assessment was accurately completed after the resident had an unwitnessed fall on 2/4/25. * The facility failed to ensure Resident 7's post fall neurological assessment was accurately completed after the resident had a fall on 1/23/25. These failures had the potential for a delay in providing care to these residents. Findings: 1. Review of the facility's P&P titled Neurological Assessment revised October 2010 showed under Documentation Information, the assessment data obtained during the procedure, should be recorded in the resident's medical record. Review of the facility's P&P titled Charting and Documentation revised July 2017 showed: - The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. - To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical record. Review of the facility's P&P titled Falls Management Program revised January 2019 showed a neurocheck will be initiated by the Licensed Nurser on unwitnessed fall and when there is identified head injury. Medical record review for Resident 685 was initiated on 2/7/25. Resident 685 was admitted to the facility on [DATE]. Review of Resident 685's progress note dated 2/4/25 at 1445 hours, showed Resident 685 had an alleged fall earlier during the day. Resident 685 was observed to have a bump with skin discoloration to the left side of his forehead. Review of Resident 685's Neurological Assessment initiated on 2/4/25 at 1430 hours, showed the following key code: - numbers 1 through 6 (with different sizes of dots and circles correlating next to the number) for the pupil size; and (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- S for sluggish, B for brisk and N for nonreactive for the reaction. Under the R (right) Pupil Size/ Reaction section showed S/S on the following dates/times: - 2/4/25 at 1430 hours; - 2/4/25 at 1445 hours; - 2/4/25 at 1500 hours; - 2/4/25 at 1515 hours; - 2/4/25 at 1545 hours; and - 2/4/25 at 1615 hours. However, review of Resident 685's medical record showed there were no interventions implemented to address the sluggish right pupil reaction documented on the dates/times listed above. In addition, the entry for the Upper Extremity and Lower Extremity section on the assessment for 2/5/25 at 0515 hours, was blank. On 2/7/25 at 1007 hours, an interview and concurrent medical record review of Resident 685's post fall Neurological Assessment initiated on 2/4/25, was conducted with RN 2. RN2 acknowledged and verified the above findings. On 2/7/25 at 1619 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged and verified the above findings. 50967 2. Review of facility's P&P titled Falls Management Program revised on 1/2019 showed the following: - The Licensed Nurse will initiate a plan of care within 24 hours from admission or readmission on residents identified as high risk for fall; - A neuro-check will be initiated by the Licensed Nurse on unwitnessed fall and when there is identified head injury; and - 72 hours observation of the resident post fall will be initiated by the Licensed Nurse. Medical record review for Resident 7 was initiated on 2/5/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 10/31/24, showed Resident 7 could make her needs known but could not make medical decisions. Resident 7's surrogate decision maker was her daughter. Review of Resident 7's MDS dated [DATE], showed Resident 7's BIMS score was 14, indicating intact cognition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 7's Neurological assessment dated [DATE], showed the key code for Pupil size was from 1-6 and Pupil reaction was Sfor Sluggish, B' for Brisk and N for Nonreactive. Resident 7's Neurological Assessment results showed the following: - on 1/23/25, from 1445-1500 hours, the Right Pupil Size was documented with the letter B (instead of a number from 1 through 6) and the Right Pupil Reaction documented with the letter S; - on 1/23/25, from 1600-2030 hours, the Right Pupil Size was documented with the letter B (instead of a number from 1 through 6); and - on 1/23/25, from 1445-2030 hours, the Left Pupil Size was documented with with letter B (instead of a number from 1 through 6). Review of Resident 7's medical record failed to show documented interventions implemented to address the resident's sluggish right pupil reaction documented on 1/23/25. On 2/5/25 at 1140 hours, an interview and concurrent medical record review was conducted with LVN 2. Resident 7's Neurological Assessment was reviewed with LVN 2. LVN 2 stated she was the licensed nurse assigned to Resident 7 when the resident fell on [DATE]. LVN 2 verified she completed Resident 7's Neurological Assessment on 1/23/25. LVN 2 verified the above findings. On 2/5/25 at 1144 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 reviewed Resident 7's Neurological Assessment and verified the above findings. RN 3 stated the Neurological assessment results and documentation must be accurate and correspond to the key code on the assessment. On 2/7/25 at 1353 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated he checked all the post fall assessments and documentation for accuracy and completion. The DON verified the inaccurate documentation on Resident 7's Neurological assessment dated [DATE]. The DON was informed and acknowledged the above findings.

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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 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** 50967 Based on observation, interview, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent further falls and/or injuries for one two of three final sampled residents (Resident 7) reviewed for falls. * The facility failed to implement Resident 7's care plan interventions to address the resident's risk for falls, including the resident fall risk monitoring, star sticker to the resident's room, and colored arm band. This failure post the risk for the resident to sustain further falls and/or injuries. Findings: Review of facility's P&P titled Managing Falls and Fall Risk revised on 3/2018 showed the staff member will monitor and document each of the resident's response to interventions intended to reduce falling or the risks of falling. Medical record review for Resident 7 was initiated on 2/5/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 10/31/24, showed Resident 7 could make her needs known but could not make medical decisions. Resident 7's surrogate decision maker was her daughter. Review of Resident 7's MDS dated [DATE], showed Resident 7's BIMS score was 14, indicating intact cognition. a. Review of Resident 7's plan of care showed a care plan problem dated 1/23/25, addressing the resident's high risk for falls and injury related to her status post fall. The interventions showed to condcuct the facility rounds every two hours by the designated staff. Reviewed Resident 7's Fall Risk Monitoring Table for monitoring the resident showed multiple missing documentation from the licensed nurses and CNAs on the following dates and times: - dated 1/24/25, from 1400-0000 hours; - dated 1/26/25, from 1400-0000 hours; - dated 1/27/25, from 1400-0000 hours; - dated 1/28/25, from 1600-0000 hours; - dated 1/29/25, from 1600-0000 hours; - No fall monitoring table form for 1/30/25; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No fall monitoring table form for 1/31/25; - dated 2/1/25, from 1600-0000 hours; - dated 2/2/25, from 1600-0000 hours; - dated 2/3/25, from 0000-0000 hours; - No fall monitoring table form for 2/4/25; and - No fall monitoring table form for 2/5/25. On 2/5/25 at 1150 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the post fall monitoring for the residents must be completed and documented every two hours for three months. LVN 2 stated the Fall Risk Monitoring Table forms were kept only in the binder and placed in the nurse's station. When LVN 2 was asked who was responsible for monitoring the resident's post fall and documenting in the Fall Risk Monitoring Table, LVN 2 stated the assigned CNAs and licensed nurses were responsible for doing the rounds and completing the form. LVN 2 stated she was supposed to check before her shift ended if the Fall Monitoring Table was completed. LVN 2 further stated if the Fall Risk Monitoring Table was not signed, then the form was incomplete. b. Review of Resident 7's progress notes did not show the post fall monitoring on the following dates and shifts: - on 1/24, 1/25, and 1/26/25, for the 7-3 shift (0700-1500 hours). On 2/5/25 1206 hours, a follow up interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the post fall monitoring and documentation from the licensed nurses must be documented on the resident's progress notes every shift for 72 hours. c. On 2/5/25 at 1100 hours, an interview as conducted with Resident 7. Resident 7 stated she had a fall on 1/23/25, inside the restroom, when she tried to stand up by herself from the wheelchair and hit her face. Resident 7 stated the wheelchair's brakes were not locked. Review of Resident 7's plan of care showed a care plan problem dated 1/23/25, addressing the resident's high risk for fall and injury related to her status post fall. The interventions included the following: - Star sticker will be placed at the resident's name under the room identifier to alert staff of the high risk for fall; and - Colored arm band will be applied by the nursing staff to the resident identified as high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 1222 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2 for Resident 7. There was no star shaped sticker observed next to Resident 7's name on the door and the resident did not have a colored arm band on. LVN 2 verified the findings. When LVN 2 reviewed Resident 7's care plan addressing the resident's fall on 1/23/25, LVN 2 verified the care plan interventions included to place a colored arm band on the resident and a star sticker on the resident's name by the door. On 2/7/25 at 1353 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated he checked all the post fall assessments and documentations for accuracy and completion. The DON further stated the facility's fall prevention program was to start the monitoring the resident every two hours for three months, the next day after the fall and the nursing staff would document on the form after every two hours. The DON verified Resident 7's Fall Risk Monitoring Table had multiple missing documentations. The DON was informed and acknowledged the above findings.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and the facility P&P review, the facility failed to maintain the acceptable parameters for fluid intake for one of one final sampled resident (Resident 9) reviewed for hydration status. * The facility failed to ensure Resident 9 was monitored when her fluid intake was above the parameter as documented by the CNAs. In addition, the facility failed to ensure the I&O Record documentation was accurate. This failure had the potential for Resident 9 to have fluid overload and negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Intake and Output revised date 10/12/20, under the Procedures for Measuring Intake section, showed the following: - The CNA shall measure and record oral fluids taken by the resident during meals and during care; - The CNA shall inquire from the resident, family members, and/or visitors if the resident has consumed additional fluids and record the volume; - The licensed nurse shall measure oral fluids taken by the resident during medication pass; and - The licensed nurse shall total the oral fluids recorded by the CNA, consumed during medication pass, and IV fluids received during the shift and record total volume on intake and output record. In addition, under the Weekly Review section, showed the intake and output record shall be reviewed by a designated licensed nurse on a weekly basis to determine adequate and fluid balance, and deficiencies in fluid intake or fluid balance shall be reported to the physician by the licensed nurse. Medical record for Resident 9 was initiated on 2/5/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 10/15/24, showed Resident 9 had the capacity to understand and make decision. Review of Resident 9's Order Summary Report showed a physician's order dated 1/16/25, for a fluid restriction of 1000 ml/ day. The nursing department was to provide a total of 280 ml with a breakdown of 120 ml in the day shift, 120 ml in the evening shift, and 40 ml in the NOC shift. The dietary department was to provide a total of 720 ml with a breakdown of 120 ml for breakfast, 300 ml for lunch, and 300 ml for dinner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 9's Documentation Survey Report v2 form for January and February 2025 showed Resident 9's fluid intake was more than the allowed 720 ml for the dietary department as shown in the following daily totals for Resident 9's fluid intake: - On 1/28/25, Resident 9's fluid intake from her meals was 950 ml; - On 1/29/25, Resident 9's fluid intake from her meals was 1160 ml; - On 2/1/25, Resident 9's fluid intake from her meals was 910 ml; - On 2/2/25, Resident 9's fluid intake from her meals was 950 ml; - On 2/4/25, Resident 9's fluid intake from her meals was 1260 ml; and - On 2/5/25, Resident 9's fluid intake from her meals was 960 ml. b. Review of Resident 9's MAR for January and February 2025 showed the documentation of Resident 9's fluid intake was marked by checks and initials. The MAR did not show Resident 9's actual fluid intake from the nursing department. c. Review of Resident 9's Intake and Output Records for January and February 2025 did not show Resident 9's total daily fluid intakes from the fluids consumed during the meals as recorded by the CNAs and the fluids consumed during the medication administration. The total daily fluid intakes from the dietary and nursing departments were not accurate as shown in the following: - On 1/28/25, the total daily fluid intake recorded was 960 ml; - On 1/29/25, the total daily fluid intake recorded was 960 ml; - On 2/1/25, the total daily fluid intake recorded was 910 ml; and - On 2/2/25, the total daily fluid intake recorded was 960 ml. On 2/6/25 at 0837 hours, an interview for Resident 9 was conducted with CNA 9. When asked about Resident 9's fluid restriction, CNA 9 stated Resident 9's fluid limit from her meals was 1500 ml per day but she was not sure how much the resident was allowed per meal. CNA 9 stated they documented Resident 9's fluid intake from her meals in the electronic health record. On 2/6/25 at 0844 hours, an interview and medical record review for Resident 9 was conducted with LVN 2. When asked about the documentation of Resident 9's fluid intake, LVN 2 stated the nursing department documented Resident 9's fluid intake in the Intake and Output Record. When asked if the documentation in Resident 9's Intake and Output Record was only for the nursing department, LVN 2 stated it was for both the fluid intake from the medication administration, as documented by the LVNs, and from the meal intake, as documented by the CNAs. LVN 2 stated the nursing department had a list that they followed, to which she showed a print-out of Resident 9's fluid restriction breakdown, showing 300 ml for the nursing department and 700 ml for the dietary department. LVN 2 verified the fluid restriction breakdown printed on Resident 9's Intake and Output Record did not match the fluid restriction breakdown as per the physician's order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 0858 hours, an interview and medical record review for Resident 9 was conducted with RN 4. RN 4 verified the above findings. RN 4 verified the CNAs documentation for Resident 9's fluid intake was more than the dietary fluid limit for the resident. RN 4 also verified Resident 9's fluid intake was more than the daily limit of 1000 ml/day on 1/29 and 2/4/25, as documented by the CNAs. RN 4 was not able to show documented evidence the physician was notified nor Resident 9 was monitored for non-compliance and for fluid overload.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure six of six final sampled residents (Residents 11, 28, 32, 37, 44, and 685) reviewed for respiratory care were provided with the appropriate respiratory care and services when: * The facility failed to ensure Residents 11, 32, 37, 44, and 685 were receiving the correct rate of oxygen as per the physician's order. * The facility failed to ensure Resident 28's nebulizer set-up was changed weekly as per the facility's P&P. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration revised October 2010 showed the staff member should verify that there is a physician's order for the oxygen administration and to review the physician's orders or facility protocol for oxygen administration. 1. On 2/4/25 at 1425 hours, during the initial tour of the facility, Resident 44 was observed awake and sitting on the bed. Resident 44's oxygen concentrator was observed on at 2.5 liters per minute. Resident 44 stated she used the oxygen on and off if she felt short of breath. Resident 44 stated she just used the oxygen. When asked, Resident 44 further stated she did not know how to change the rate of the oxygen on the oxygen concentrator and it was turned on all the time. Medical record review for Resident 44 was initiated on 2/4/25. Resident 44 was admitted to the facility 12/13/24. Review of Resident 44's H&P examination dated 12/13/24, showed Resident 44 could make needs known but could not make medical decisions. Review of Resident 44's Order Summary Report showed a physician's order dated 1/17/25, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. On 2/4/25 at 1500 hours, an observation, interview, and concurrent medical record review was conducted with LVN 5 for Resident 44. Resident 44 was awake and sitting on the wheelchair. Resident 44's oxygen machine was observed on at 2.5 liters per minute. LVN 5 stated Resident 44 had a physician's order for oxygen at two liters per minute continuously. When LVN 5 asked Resident 44 if she used the oxygen, Resident 44 stated she just did. LVN 5 verified the oxygen machine was on at 2.5 liters per minute. LVN 5 further stated Resident 44 was not receiving the correct rate of oxygen per the physician's order, and would instruct the resident to inform the facilty staff member when she was feeling short of breath. On 2/7/25 at 1610 hours, the DON was informed and acknowledged the above findings for Resident 44. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45064 2. On 2/4/25 at 1426 hours, during the initial tour of the facility, Resident 32 was observed lying in bed and receiving oxygen at three liters per minute via nasal cannula. Medical record review for Resident 32 was initiated on 2/4/25. Resident 32 was readmitted to the facility 6/11/24. Review of Resident 32's H&P examination dated 6/12/24, showed Resident 32 had no capacity to understand and make decisions. Review of Resident 32's Order Summary Report showed a physician's order dated 6/11/24, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath or oxygen saturation less than 92% on room air. On 2/4/25 at 1633 hours, an observation, interview, and concurrent medical record review was conducted with RN 1 for Resident 32. Resident 32 was observed receiving oxygen at three liters per minute via nasal cannula. RN 1 verified Resident 32 had a physician's order for oxygen at two liters per minute. 3. On 2/4/25 at 1428 hours, during the initial tour of the facility, Resident 37 was observed awake and lying in bed. Resident 37 was observed receiving oxygen at three liters per minute via nasal cannula. Medical record review for Resident 37 was initiated on 2/4/25. Resident 37 was readmitted to the facility 11/18/24. Review of Resident 37's H&P examination dated 11/18/24, showed Resident 37 had no capacity to understand and make decisions. Review of Resident 37's Order Summary Report showed a physician's order dated 2/4/25, to administer continuous oxygen at two liters per minute via nasal cannula to maintain oxygen saturation above 92%. On 2/4/25 at 1638 hours, an observation, interview, and concurrent medical record review was conducted with RN 1 for Resident 37. Resident 37 was observed receiving oxygen at three liters per minute via nasal cannula. RN 1 verified Resident 37 should be receiving oxygen at two liters per minute as per the physician's order. RN 1 was observed adjusting Resident 37's oxygen rate to two liters per minute. 50787 4.a. On 2/4/25 at 1350 hours, during the initial tour of the facility, Resident 685 was observed lying in bed and receiving oxygen at less than one liter per minute via nasal cannula. Medical record review for Resident 685 was initiated on 2/4/25. Resident 685 was admitted to the facility 1/28/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 685's Order Summary Report dated 2/6/25, showed a physician's order dated 1/28/25, to administer oxygen at two liters per minute via nasal cannula continuously every shift for SOB (shortness of breath), to maintain oxygen saturation greater than 92%. Review of Resident 685's MAR for January 2025 showed LVN 3 administered oxygen at two liters per minute via nasal cannula continuously to Resident 685 on 2/4/25. On 02/4/25 at 1528 hours, an observation and concurrent interview was conducted with LVN3 for Resident 685. LVN 3 stated Resident 685's oxygen order was for two liters per minute. LVN 3 verified Resident 685's current oxygen setting was at less than one liter per minute. When asked, LVN 3 stated Resident 685's oxygen setting was not correct and should be at two liters per minute. b. Review of Resident 685's Order Summary Report for January and February 2025 showed there was no physician's order for the oxygen saturation monitoring. Review of Resident 685's MAR for January and February 2025 showed no entries were documented for the oxygen saturation monitoring results. On 2/7/25 at 1029 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 685. RN2 stated I checked the order, but there is no order for this resident, the oxygen saturation is documented in the progress notes. Review of Resident 685's progress notes from 1/28 to 2/6/25, showed Resident 685's oxygen saturation results were documented only on 1/30 and 2/4/25. On 2/7/25 at 1619 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged and verified the above findings. 51920 5. On 2/4/25 at 1405 hours, Resident 11 was observed lying in bed and receiving three liters per minute of oxygen via nasal cannula. On 2/5/25 at 0910 hours, Resident 11 was observed lying in bed and receiving four liters per minute of oxygen via nasal cannula. Medical record review for Resident 11 was initiated on 2/4/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed a physician's order dated 12/9/24, to administer oxygen inhalation continuously at two liters per minute via nasal cannula every shift for respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide)/hypoxia (low oxygen level). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 0915 hours, an observation for Resident 11 and concurrent interview was conducted with LVN 2 and the DSD. Resident 11 was observed lying in bed and receiving four liters per minute of oxygen via nasal cannula. LVN 2 and the DSD verified Resident 11 was receiving four liters per minute of oxygen via nasal cannula. LVN 2 stated Resident 11 was receiving the incorrect rate of oxygen and the oxygen order for Resident 11 was for two liters per minute of continuous oxygen via nasal cannula. The DSD stated she verified the oxygen rate for Resident 11 earlier in the morning and it was correctly set at two liters per minute. LVN 2 and the DSD both stated they did not know who was adjusting Resident 11's oxygen rate. LVN 2 was then observed adjusting Resident 11's oxygen rate to two liters per minute on the oxygen concentrator. 39453 6. Review of the facility's P&P titled Respiratory Therapy - Prevention of Infection dated 11/15/23, under the Infection Control Considerations Related to Medication Nebulizers/ Continuous Aerosol section, showed to discard the administration set-up every seven days. On 2/4/25 at 1430 hours, during the initial tour of the facility, Resident 28 was observed in bed and asleep. A nebulizer mask and tubing were observed inside a set-up dated 1/27/25. On 2/4/25 at 1504 hours, an observation and concurrent interview was conducted with LVN 2 for Resident 28. Resident 28's nebulizer mask and tubing were observed inside a set-up bag dated 1/27/25. LVN 2 verified the above findings. LVN 2 stated the nebulizer set-up bag should be changed every Monday by the central supply staff. Medical record review for Resident 28 was initiated on 2/4/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's Order Summary Report showed the following physician's orders: - dated 1/6/25, to administer Duoneb (bronchodilator) 0.5-2.5 mg/3 ml inhale orally via nebulizer every four hours as needed for shortness of breath or wheezing; and - dated 1/25/25, to administer ipratropium-albuterol (Duoneb, bronchodilator) 0.5-2.5 mg/3 ml inhale orally every six hours for shortness of breath/ wheezing for 14 days. On 2/5/25 at 1540 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 3. RN 3 verified the above findings. RN 3 stated the respiratory equipment, such as the oxygen tubing, nebulizer mask and tubing, were usually changed by the NOC shift charge nurse weekly.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, and facility P&P review, the facility failed to provide adequate monitoring for the signs and symptoms of bleeding to ensure two of four final sampled residents (Residents 39 and 84) reviewed for anticoagulant (prevents blood clots) medication use were free from unnecessary drugs. * Residents 39 and 44 were administered with apixaban (Eliquis, blood thinner medication) without monitoring for the signs and symptoms of bleeding. These failures had the potential for the residents to develop significant side effects of bleeding and negatively affect the residents' health condition and well-being. Findings: According to DailyMed, the most common clinically adverse effect of the Eliquis medication was the risk of serious and potentially fatal bleeding. Review of the facility's P&P titled Anticoagulation - Clinical Protocol revised November 2018 showed the facility staff member should assess for any signs or symptoms related to adverse drug reactions due to the medications alone or in combination with other medication. The facility staff member should assess for the evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to the particular drug, for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding. 1. Medical record review for Resident 39 was initiated on 2/4/25. Resident 39 was readmitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 1/30/25, showed Resident 39 could make needs known but could not make medical decisions. Review of Resident 39's Order Summary Report showed a physician's order dated 1/26/25, to administer apixaban five mg one tablet by mouth two times a day for AFib (atrial fibrillation, a heart condition causing irregular heartbeat), to start on 1/27/25. Review of Resident 39's MAR for January and February 2025 showed Resident 39 received the apixaban medication on the following dates/times: - on 1/27 to 1/31/25 at 0900 and 1700 hours; - on 2/1 to 2/3/25 at 0900 and 1700 hours; and - on 2/4/25 at 0900 hours. Review of Resident 39's Care Plan initiated on 1/26/25, showed a care plan focus problem addressing Resident 39's high risk for signs and symptoms of bleeding related anticoagulation therapy due to atrial fibrillation. The interventions included the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Observe and report for signs and symptoms of bruising, bleeding of the gums, coffee ground emesis, tarry stool, and hematuria (blood in the urine); and - Report new area of bruising to the physician and responsible party/surrogate decision maker. Further review of Resident 39's medical record did not show documented evidence Resident 39 was being monitored for the signs and symptoms of bleeding. On 2/5/24 at 1450 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 stated the apixaban medication was a blood thinner and could cause bleeding. RN 3 stated the signs and symptoms of bleeding included hematuria, nosebleed, bruising, bloody stool, and gum bleeding. RN 3 stated it was very important for the licensed nurses to assess the residents who were receiving blood thinner for these signs and symptoms because it could cause fatal injury to the residents. RN 3 further stated once the resident received an order for an anticoagulant medication, the monitoring for signs and symptoms of bleeding was automatically ordered as well and it would show in the MAR, which would remind the licensed nurses to assess the residents for the signs and symptoms of bleeding. RN 3 verified there was no monitoring documented to show Resident 39 was assessed for signs and symptoms of bleeding related to the apixaban medication use. On 2/7/25 at 1610 hours, the DON was informed and acknowledged the above findings for Resident 39. 50787 2. Medical record review for Resident 84 was initiated on 2/5/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's Diagnosis Information, showed Resident 84 had acute embolism (blockage of a blood vessel) and thrombosis (blood clot) to the left femoral vein. Review of Resident 84's MDS dated [DATE], showed Resident 84 had a BIMS score of seven, indicating severe cognitive impairment. Review of Resident 84's Order Summary Report dated 2/7/25 showed the following orders: - dated 1/12/25, to administer Eliquis (blood thinner) 5 mg oral tablet two times a day for DVT (deep vein thrombosis) to the left leg for three months and to start 1/20/25. - dated 2/6/25, to check for sign of bleeding secondary to anticoagulant intake and call MD if signs of bleeding are present - gum bleeding, coffee ground emesis, hematuria, bruising, epistaxis, every shift. Review of Resident 84's MAR for February 2025 showed: - Resident 84 was administered Eliquis 5 mg twice a day from 2/1 to 2/6/25. - Resident 84 was being monitored for signs of bleeding every shift starting on 2/6/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 84's plan of care showed a care plan dated 1/12/25, addressing Resident 84's high risk for signs and symptoms of bruising and bleeding related to the anticoagulation therapy for the left leg DVT. The interventions included, to observe for signs and symptoms of bruising, bleeding of the gums, coffee ground emesis, tarry stools and hematuria, and to report new area of bruising to the MD and responsible party. On 2/6/25 at 1035 hours, an interview was conducted with LVN 4. When LVN 4 was asked on what was monitored if a resident was on anticoagulant medication, LVN 4 stated he would monitor for bleeding and bruising. LVN 4 further stated there should be a physician's order to monitor for bleeding and bruising related to the anticoagulant medication. LVN4 acknowedged and verified Resident 84 had no physician's order for monitoring the signs and symptoms of bleeding from 1/12 to 2/5/25. On 2/7/25 on 1619 hours, an interview was conducted with the DSD. When the DSD was asked if there were inservices provided to the licensed nurses regarding the monitoring of the residents on anticoagulant medication, the DSD stated no. On 2/7/25 at 1619 hours, an interview was conducted with the Administrator and DON . The Administrator and DON were informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to ensure one of five final sampled residents (Resident 9) reviewed for unnecessary medications was free from the unnecessary psychotropic medication. * The facility failed to ensure the monitoring of Resident 9's meal intake related to the use of mirtazapine (antidepressant medication) medication was accurate. In addition, the facility failed to ensure the monthly behavior summary related to the use of mirtazapine medication was completed. These failures had to potential to result in unnecessary use and ineffective monitoring for the use of psychotropic medication that could negatively affect Resident 9's well-being. Findings: Medical record review for Resident 28 was initiated on 2/4/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 10/15/24, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 10/15/24, to administer mirtazapine 7.5 mg one tablet by mouth at bedtime for depression manifested by poor oral intake/ eats less than 76% of meals; and - dated 10/16/24, to monitor and record meal intake percentage for breakfast, lunch, and dinner. Review of Resident 28's MAR for January and February 2025 showed Resident 28 was administered the mirtazapine medication on 1/1 to 2/5/25 at 2100 hours. Further review of the MAR for January 2025 showed Resident 28's meal intake were less than 76% as follows: - Resident 28 consumed 15% for dinner on 1/25/25; - Resident 28 consumed 40% for dinner on 1/24/25; - Resident 28 consumed 50% for breakfast and lunch on 1/1, 1/6 and 1/7/25, and for dinner on 1/5, 1/8, 1/14, 1/23, 1/26 and 1/31/25; - Resident 28 consumed 60% for breakfast and lunch on 1/25/25; - Resident 28 consumed 70% for breakfast on 1/4 and 1/18/25, for lunch on 1/4, 1/17, 1/18, 1/22, and 1/29/25, and for dinner on 1/3, 1/6, 1/9, 1/12, 1/15, 1/16, 1/17, 1/27, 1/28, and 1/29/25; and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 28 consumed 75% for breakfast on 1/2, 1/3, 1/8,1/9, 1/10, 1/11, 1/12, 1/17, 1/20, 1/21, 1/24, 1/26, 1/27, 1/28, 1/29, 1/30, and 1/31/25, for lunch on 1/3, 1/8, 1/10, 1/11, 1/14, 1/26, 1/28, 1/30, and 1/31/25, and for dinner on 1/10, 1/11, and 1/30/25. Review of Resident 28's Documentation Survey Report v2 for January 2025 showed the following: - Resident 28 consumed 26-50% for lunch on 1/8, 1/11, 1/12, 1/15, 1/18, 1/22, and 1/26/25, and for dinner on 1/5, 1/8, 1/14, 1/15, 1/17, 1/23, 1/24, 1/25, 1/26, and 1/30/25; and - Resident 28 consumed 51-75% for breakfast on 1/3, 1/5, 1/7, 1/8, 1/9, 1/16, 1/22, 1/26, and 1/31/25, for lunch on 1/4, 1/6, 1/7, 1/9, 1/13, 1/16, 1/20, 1/24, 1/30, and 1/31/25, and for dinner on 1/2, 1/3, 1/6, 1/9, 1/10, 1/12, 1/16, 1/18, 1/21, 1/27, 1/28, 1/29, and 1/31/25. a. Resident 28's meal intake documentation by the licensed nurses as shown in the MAR for January 2025 did not match the documentation by the CNAs as shown in the Documentation Survey Report v2 for January 2025 . b. Review of Resident 28's Psychotropic Summary Sheet for January 2025 showed the monthly behavior summary related to the use of the mirtazapine medication was not completed . On 2/6/25 at 0858 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 4. RN 4 verified the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39453 Based on observation, interview, and facility P&P review, the facility failed to ensure for the safe storage of the medications and supplies. * The facility failed to ensure Medication Cart F was not left unlocked and unattended. In addition, the facility failed to ensure the containers of the bleach wipes were not stored with a box of tuberculin syringe. * The facility failed to ensure the vitamin A&D ointment (barrier cream/ointment) was not kept at Resident 9's bedside. * The facility failed to ensure the eye and rectal medications were not stored together. These failures had the potential to result in the unsafe administration of medications, and cross-contamination of the medications. Findings: 1. Review of the facility's P&P titled Storage of Medications revised 4/2007 showed the following: - Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications; and - Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 2/5/25 at 1140, 1145, and 1147 hours, Medication Cart F parked in the hallway was observed unlocked and unattended. The facility staff member, residents, and visitors were observed passing by. On 2/5/25 at 1148 hours, an inspection of Medication Cart F and concurrent interview was conducted with the IP. Medication Cart F parked in the hallway was observed unlocked and unattended. The IP stated Medication Cart F was used as the infection control cart. The IP stated she took out isolation signages from the medication cart and she forgot to lock it. Upon further inspection, Medication Cart F was observed with a box of syringes with needles, a box of sterile bordered gauze, alcohol prep pads, and specimen vials. In addition, two containers of bleach wipes were observed stored with a box of tuberculin syringes. The IP verified the above findings. 2. On 2/4/25 at 1438 hours, during the initial tour of the facility, Resident 9 was observed awake and lying in bed. A packet of vitamin A&D ointment was observed on Resident 9's bedside table. Resident 9 stated she did not know about the ointment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 9 was initiated on 2/4/25. Resident 9 was admitted to the facility on [DATE]. Further review of Resident 9's medical record did not show a physician's order to apply vitamin A&D ointment. On 2/4/25 at 1500 hours, an observation and concurrent interview for Resident 9 was conducted with LVN 2. A packet of vitamin A&D ointment was observed on Resident 9's bedside table. LVN 2 verified the above findings. LVN 2 stated the vitamin A&D ointment was a cream used for the resident's dry skin and it was applied by the CNAs. 49324 3. Review of the facility's P&P titled Storage of Medications revised 4/2007 showed the drugs should be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. On 2/5/25 at 1301 hours, an observation of the Medication Cart A was conducted with LVN 5. The last bottom drawer of Medication Cart A was observed with cyclosporine ophthalmic emulsion (eye medication) stored together with bisacodyl suppository (medication to help bowel movement inserted in the rectum). LVN 5 stated the two medications should not be stored together. On 2/5/25 at 1606 hours, an interview was conducted with the DON. The DON acknowledged the eye medication, and the rectal medication should not be stored together in one drawer.

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed. * The pureed mixed vegetable was not the same as the regular mixed vegetable with tofu. * The pureed beef was not served with a ladle of sauce per the recipe. These failures had the potential for residents on pureed diet not receiving adequate nutrition, and negatively affect their well-being. Findings: 1. Review of the facility's Order Listing Report dated 2/4/25, showed 17 of 89 residents receiving foods prepared in the kitchen were on pureed diet. Review of the facility's P&P titled Menus revised 10/2017 showed deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived. On 2/6/25 at 1018 hours, a pureed food preparation was observed with [NAME] 1, with the DSS present. [NAME] 1 was observed preparing the pureed mixed vegetables from a pan containing cooked broccoli, zucchini and carrots. There were cauliflowers nor tofu observed in the pan of cooked mixed vegetables. On 2/6/25 at 1145 hours, during a trayline observation, a pan of regular textured mixed vegetables was observed on the trayline assembly table. The pan of regular textured mixed vegetables included cauliflower, and slices of fried tofu, and without zucchini. The DSS verified the pureed mixed vegetables were not the same as the regular mixed vegetables. 2. Review of the recipe for the Stir Fried Beef with [NAME] Peppers, Pureed dated 5/29/19, showed to serve using #6 scoop and top with one ounce of ladle of sauce. On 2/6/25 at 1145 hours, during a trayline observation, the pureed beef was not served with a ladle of sauce per the recipe. The DSS verified the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure Dietary Aide 1 performed handwashing in between glove changes and performed proper hand hygiene and glove changes between dirty and clean areas during dishwashing. * The facility failed to ensure the rusty cooling steel racks were not stored with clean kitchen utensils. * The facility failed to ensure a spatula stored in a drawer had a smooth, easily cleanable surface. * The facility failed to ensure the plate lowerator and microwave were clean. * The facility failed to ensure kitchen employee belongings were not stored on a shelf used to store paper cups. * The facility failed to ensure the kitchen thermometers were calibrated properly. * The facility failed to ensure the sanitizing solutions in the sanitizer buckets were checked and documented. * The facility failed to ensure the food preparation area was clean and free from the used gloves and used paper towels. * The facility failed to ensure the DSS and Dietary Aide 1 did not use paper towels to dry the newly washed kitchen utensils. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumes food prepared from the kitchen. Findings: Review of the facility's document titled Order Listing Report dated 2/4/25, showed 89 of 95 residents in the facility received food prepared in the kitchen. Review of the facility's P&P titled Sanitation revised 10/2008 showed the following: - All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, and flies, and other insects; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- All the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair; - Between uses, the cloths, and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizing solution will be changed at least once per shift or if solution becomes cloudy or visibly dirty; -Plasticware, China and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze shall be discarded; and - The Food Service Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. 1. According to the USDA Food Code 2022, Section 2-301.14, When to Wash, food employees shall clean their hands before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. Review of the facility's P&P titled Glove Use Policy dated 2018 showed gloved hands are a considered a food contact surface and should be discarded after each use, and especially before handling clean food items. Wash hands when changing to a fresh pair. Gloves must never be used in place of handwashing. On 2/6/25 at 1034 hours, Dietary Aide 1 was observed washing the dishes in the dishwashing dirty area with gloves on. Dietary Aide 1 was observed removing the glove on her right hand, went to the clean area, and used her bare right hand to open the door of the dishwasher and retrieved the plastic dish rack with the Robot Coupe. Then Dietary Aide 1 was observed removing the glove on the left hand, washing her hands, and donning clean gloves. On 2/6/25 at 1040 hours, the dishwashing area was observed to be in an L-shaped design, with the dishwasher positioned centrally at the intersection, and Dietary Aide 1 with both gloves on, was observed standing in front of the dishwasher. Dietary Aide 1's gloved left hand was on the dirty area, and Dietary Aide 1 used her gloved right hand to retrieve the plastic rack with cups from the dishwasher. Then Dietary Aide 1 was observed removing both gloves, washing her hands, and donning clean gloves. On 2/6/25 at 1430 hours, an interview was conducted with Dietary Aides 1 and 2. Dietary Aide 1 verified the above findings. 2. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/5/25 at 0922 hours, two rusty steel racks were observed stored with ladles and tongs inside a drawer; and one rusty steel rack was observed stored with a rolling pin and ladles inside another drawer. The DSS verified the above findings. b. On 2/5/25 at 0930 hours, the microwave used to warm the residents' food items was observed with cracked and rusty inside panel. The DSS verified the above findings. c. On 2/6/25 at 1134 hours, the plate warmer equipment was observed covered by two lids. However, the hinges securing the lids showed visible dirt accumulation and rust. The DSS verified the above findings. d. On 2/6/25 at 1050 hours, during the pureed food preparation observation with [NAME] 1, with the DSS and RD 2 present. The food preparation area was observed with used gloves and used paper towel. The DSS and RD 2 verified the above findings. 3. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 2/5/25 at 0922, a spatula with chipped edges was observed stored with other kitchen utensils inside a drawer. The DSS verified the above findings. 4. According to the USDA Food Code 2022, Section 6-305.11 Designation, showed street clothing and personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are required for articles such as purses, coats, shoes, and personal medications. Review of the facility's P&P titled Employee Personal items dated 2018 showed the employees bringing in personal items from outside such as jackets, cell phones, keys, purses, etc. will not be kept in the kitchen area. On 2/4/25 at 1318 hours, a purse was observed stored on the shelf used for paper cups. The DSS verified the above findings. The DSS stated the facility had a cabinet used for the kitchen staff member to store their personal property. 5. According to the USDA Food Code 2022, Section, 4-502.11 Good Repair and Calibration, showed the food temperature measuring devices shall be calibrated in accordance with manufacturer's specifications as necessary to ensure their accuracy. Review of the product manual for [NAME] 3621n Pocket Thermometer, under Recalibration section, showed to attach the thermometer sleeve over the stem aligning the hex nut with the wrench, immerse the thermometer stem at least two inches into the slurry at 32 degrees F, and let the temperature stabilize and use the wrench to rotate the hex nut until the thermometer reads 32 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the product manual for [NAME] 9848FDA Waterproof Digital Thermometer, under Calibration section, showed to suspend probe at least one inch into a slush of crushed ice and water at 32 degrees F for at least 30 seconds, and to keep the probe from touching the container bottom. Review of the facility's P&P titled Thermometer Use and Calibration dated 2018 under Checking the Accuracy and Calibrating section, showed the following: - The food thermometers are to be calibrated each week, after one is dropped or when a thermometer is new. It is recommended to put thermometer calibration on a cook's duties/ sanitation list that must be initialed upon completed; - Fill a large glass with crushed ice and add clean tap water until a slush is formed. Stir the mixture well; and - Put the thermometer's stem into the ice water so that the sensing area is completely submerged. Do not let the stem touch the bottom or the sides of the glass. The thermometer stem or probe must remain in the ice water one minute and during the calibration process. On 2/6/25 at 1139 hours, a thermometer calibration procedure was observed with [NAME] 1. [NAME] 1 showed two [NAME] 3621n pocket thermometers, and one [NAME] 9848FDA digital thermometer inside a brown cup with ice and water. [NAME] 1 did not use the thermometer sleeves of the pocket thermometers. The stems of the thermometers were observed submerged and touching sides of the cup. The two pocket thermometers read at 32 degrees F, and the digital thermometer read at 39 degrees F. [NAME] 1 and the DSS verified the above findings. 6. According to the USDA Food Code 2022, Section 4-701.10, Food Contact Surfaces and Utensils, showed effective sanitization procedures destroy organisms of public health importance that may be present on wiping cloths, food equipment, or utensils after cleaning, or which have been introduced into the rinse solution. On 2/525 at 0901 hours, an observation and concurrent interview was conducted with Dietary Aide 1, with the DSS present. Dietary Aide 1 was asked to demonstrate how to check the sanitizing solution in the red sanitizing bucket. Dietary Aide 1 obtained the chlorine testing strips and dipped into the red sanitizing bucket. Dietary Aide 1 stated the kitchen staff member checked the ppm whenever the sanitizing solution in the red bucket was changed and documented on the log. Review of the Dish Machine Temperature and Sanitizer Check Log for January and February 2025 only showed a column for red bucket sanitizer change and the column was marked with checkmarks. There was no documentation to show the test results of sanitizer solution of the red sanitizing bucket. The DSS verified the above findings. 7. According to the USDA Food Code 2022, Section 4-901. 11, Equipment and Utensils, Air-Drying Required, showed after cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/5/25 at 0901 hours, the DSS with both gloves on was observed retrieving a clean rack with cups and using paper towels to dry the newly washed cups in the dishwashing area. Then the DSS was observed taking the clean rack with cups and placing them on a shelf. Then the DSS was observed retrieving a clean rack with bowls and using the same paper towels to dry the newly washed bowls in the dishwashing area. On 2/5/25 at 0918 hours, an interview was conducted with the DSS. The DSS verified the above findings. The DSS stated he used the paper towel to dry the little drops of water to help dry the dishes. b. On 2/6/25 at 1034 hours, during the pureed food preparation observation with [NAME] 1, Dietary Aide 1 was observed washing the measuring spoon, taking the measuring spoon from the dishwasher, and drying it off with a paper towel. Dietary Aide 1 gave the measuring spoon to [NAME] 1 and [NAME] 1 used it to measure the thickener in the pureed beef. Dietary Aide 1 verified the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39453 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the facility staff assisted the residents regarding the use and storage of food brought in by the family member or visitors for the residents. * The facility failed to ensure the safe handling and storage of food from outside sources to be included in the facility's P&P. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources. Findings: Review of the CMS S&C-09-39 Food Procurement, and Self-Determination and Participation dated 5/29/09, showed the following: - The residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices; and - The facility has the responsibility under the food safety regulation to help visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Foods Brought by Resident, Family member and Visitor dated 3/2010 showed the following: -Non-perishable foods permitted to be retained in the resident's room must be stored in plastic containers with tight-fitting lids, except fresh fruit; and -Resident is requested to eat perishable food brought by the resident, family members/ visitors right away, and left over will be disposed as indicated. On 2/5/25 at 0855 hours, an interview was conducted with RN 3. When asked about the foods brought by the residents, resident's family members, and visitors from outside sources, RN 3 stated the facility did not have a separate refrigerator used for the food items from outside sources. RN 3 stated the residents, family members, and visitors could ask the kitchen to store any food items from outside sources. On 2/5/25 at 0858 hours, an interview was conducted with the DSS. When asked about the foods brought by the residents, resident's family members, and visitors from outside sources, the DSS stated the residents, resident's family members, and visitors could bring food from home, and the kitchen staff member could store the food from home in the reach-in refrigerator in the kitchen. The DSS stated there was a separate rack in the reach-in refrigerator to be used to store the food from home, however, it needed to be served right away, and the facility did not do overnight storage of foods brought by residents, resident's family members, and visitors from outside sources. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 1500 hours, an interview and concurrent facility P&P review was conducted with the DSS and RD 1. The DSS and RD 1 verified the facility's P&P on Foods Brought From Home did not show the safe food handling and safe storage in the reach-in refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, and facility document review, the facility failed to maintain the infection control program and practices as evidenced by: * Room A did not have a receptacle to dispose of used or soiled gowns. * The infection surveillance logs failed to accurately document the infections in the facility. * Mapping for infections did not accurately reflect all the HAIs. * The facility failed to ensure Resident 44's nasal cannula was stored in a sanitary manner. * The facility failed to ensure the medication carts were kept clean. * The facility failed to ensure the facility staff followed the EBP for Resident 688 as per the physician's order. These failures posed the risk for transmission and development of disease-causing microorganisms. Findings: 1. On 02/4/25 at 1400 hours, during the initial tour of the facility, Room A was observed to be an Enhanced Barrier Precautions isolation room. Room A was observed without a receptacle to dispose of used gowns. On 02/4/25 at 1510 hours, LVN 1 was observed at Room A door, handing his used gown to CNA 1. When asked about a receptacle to dispose of used gowns for Room A, LVN 1 verified there was no receptacle to dispose of used gowns for Room A. 2. On 2/6/25 at 1104 hours, an interview about the facility's infection control program was conducted with the IP. When asked how she was made aware of the infections in the facility, the IP stated she checked the daily change of conditions report for each of the nurse stations. When asked about identifying and keeping track of the infections in the facility, the IP stated she categorized the infections into three categories: CAI, HAI, and those that did not meet the McGeer's criteria. Review of the facility's December 2024 Infection Surveillance Log showed 10 of the 12 HAI infections were not identified as being HAIs. Further review of the log showed a total of 10 cases of pneumonia infections, with the onset dated after the resident was admitted . For example, Resident 32 was admitted [DATE] and the onset of pneumonia with antibiotic use was on 12/26/24. The log did not show this infection was identified as an HAI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2025 Infection Surveillance Log showed 19 of the 23 HAI infections were not identified as being HAIs. Further review of the log showed a total of 11 cases of pneumonia infections and a total of five ESBL infections; with the onset dates after the residents' admission. When asked about identifying infections as HAIs, the IP was not able to correctly identify when an infection was an HAI. 3. Review of the December 2024 and January 2025 mapping of infections showed a ledger to identify the C for CAI, H for HAI, D for did not met the McGeer's criteria, and with different color code for the site of infection (UTI/Foley, UTI/no Foley, respiratory, wound and skin, GI, eyes and ears, blood, and others). However, further review of the mapping for the facility's infections failed to identify all the HAI infections from the Infection Control Surveillance Log. The IP stated if the resident did not met the McGeer, the facility did not identify in the mapping if the resident's infection was an HAI. In addition, review of the December 2024 and January 2025 Infection Surveillance Log under the section sign and symptoms, showed the residents assessed with increased confusion were asymptomatic. On 2/6/25 at 1104 hours, an interview and concurrent facility's infection control program was conducted with the IP. When asked about the documentation asymptomatic for the residents with confusion, the IP was unable to explain the reason why the residents assessed with confusion was identified as asymptomatic on the log. The IP was informed and verified the above findings. 49258 4. On 2/4/25 at 1425 hours, during the initial tour of the facility, Resident 44 was observed awake and sitting on the bed. Resident 44's oxygen concentrator was observed turned on and the nasal cannula was observed on the floor without any storage bag or plastic. Resident 44 stated she used the oxygen on and off if she felt short of breath. Resident 44 stated she just used the oxygen. Medical record review for Resident 44 was initiated on 2/4/25. Resident 44 was admitted to the facility 12/13/24. Review of Resident 44's H&P examination dated 12/13/24, showed Resident 44 could make needs known but could not make medical decisions. Review of Resident 44's Order Summary Report showed a physician's order dated 1/17/25, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. On 2/4/25 at 1500 hours, an observation and concurrent interview was conducted with LVN 5 for Resident 44. Resident 44 was awake and sitting in the wheelchair. Resident 44's oxygen concentrator was observed turned on and the nasal cannula was on the floor without any storage bag or plastic. LVN 5 stated Resident 44 had an order for continuous oxygen. LVN 5 was observed picking up the nasal cannula from the floor and was about to put it back in Resident 44's nose. LVN 5 was stopped and reminded the nasal cannula was on the floor without any storage bag or plastic. LVN 5 stated she would throw the nasal cannula away and provide the resident with a new one. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 1223 hours, an interview was conducted with the IP. The IP stated the oxygen nasal cannula should not be reused when found on the floor or touching any other environment surfaces because it could be a source of infection. The IP was informed and acknowledged the above findings for Resident 44. 49324 5. On 2/5/25 at 0800 hours, an observation of Medication Cart A was initiated with LVN 5. Medication Cart A's top surface where the nurses prepare the medications was observed with hardened and dried light yellow cream color medication residue. LVN 5 was unable to remove the residue. LVN 5 stated it should have been cleaned right away when spillage happened to prevent the hardening of the medication residue. LVN 5 further stated the importance of cleaning the top surface for any medication residue for the infection prevention and control. On 2/5/25 at 0831 hours, an observation of Medication Cart B was initiated with LVNs 1 and 3. Medication Cart B's top surface where the nurses prepare the medications was observed with hardened and dried light yellow cream color medication residue. LVN 1 was unable to remove the residue. LVN 3 stated the medication residue should have been cleaned immediately to prevent from sticking to the top surface of the medication cart. LVN 3 further stated the importance of cleaning the medication residue to prevent infection. On 2/5/25 at 0853 hours, an observation of Medication Cart C was initiated with LVNs 2 and 3. Medication Cart C's top surface where the nurses prepare the medications was observed with hardened and dried light yellow cream color medication residue. LVN 3 stated the medication residue should have been cleaned immediately as well for infection prevention and control. On 2/5/25 at 1421 hours, the DON was notified and acknowledged the above findings. 50787 6. Medical record review for Resident 688 was initiated 2/6/25. Resident was admitted to the facility on [DATE]. Review of Resident 688's Diagnosis Information showed Resident 688 had urinary tract infection as the admitting diagnosis and ESBL Resistance (when bacteria produce enzymes that make them resistant to certain medications used to treat infections). Review of Resident 688's Order Summary Report dated 2/6/25, showed a physician's order dated 1/31/25, for Enhanced Barrier Precaution for ESBL in the urine. On 2/6/25 at 0854 hours, an observation of Resident 688's room showed no indication the resident was on EBP. There was no EBP signage by the resident's door. On 2/6/25 at 0900 hours, an interview was conducted with CNA 5. When asked on how she identified a resident on EBP, CNA 5 stated there would be a sign by the resident's door. CNA 5 stated Resident 688 was not on EBP because he had no catheter (a thin, flexible tube inserted into the bladder to drain urine). CNA 5 verified there was no sign by the resident's door indicating the EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 1046 hours, an interview, observation, and concurrent medical record review was conducted with the IP. The IP was asked about Resident 688's current physician's order for EBP. The IP stated the facility did not follow the EBP for ESBL in the urine unless the resident had a urinary indwelling catheter. The IP verified there was no EBP signage by Resident 688's door. The IP further stated, it was a mistake in the order. On 2/6/25 at 1447 hours, an interview was conducted with RN 3 regarding Resident 688's EBP order. RN 3 stated with or without a catheter, the resident should be on EBP. RN 3 further stated Resident 688 had active ESBL infection. RN 3 verified that there was no EBP signage on Resident 688's door. On 2/7/25 at 1619 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged and verified the above findings.

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	02/07/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 35346 Based on interview and medical record review, the facility failed to ensure the McGeer's Criteria for Infection Surveillance Checklist were completed for one of 20 final sampled residents (Resident 685) reviewed for antibiotic medication use. This failure posed the risk of the continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic resistant bacteria. Findings: 1. On 2/7/25 at 1132 hours, an interview and concurrent medical record review for Resident 685 was conducted with the IP. The IP verified Resident 685 was administered two different antibiotics (azithromycin and cefepime) on 1/28/25 and one of the antibiotic (cefepime) dose was increased on 1/29/25. The IP verified she failed to complete the McGeer Criteria for Infection Surveillance Checklist to follow up on the use of the antibiotics. 2. On 2/6/25 at 1104 hours, an interview about the facility's infection control program was conducted with the IP. When asked how she was made aware of the infections in the facility, the IP stated she checked the daily change of conditions report for each of the nurse stations. When asked about identifying and keeping track of the infections in the facility, the IP stated she categorized the infections into three categories: CAI (Community Acquired Infection), HAI, and those that did not meet the McGeer's criteria. Review of the facility's December 2024 Infection Surveillance Log showed 10 of the 12 HAI infections were not identified as being HAIs by the IP. Review of the January 2025 Infection Surveillance Log showed 19 of the 23 HAI infections were not identified as being HAIs by the IP. When asked about identifying the infections as HAIs, the IP stated if the residents' infection did not met the McGeer criteria then the facility did not track anymore if the infection was an HAI. 3. Review of the December 2024 and January 2025 Infection Surveillance Log under the section sign and symptoms, showed the residents assessed with increased confusion were asymptomatic. On 2/6/25 at 1104 hours, an interview and concurrent facility's infection control program was conducted with the IP. When asked about documenting asymptomatic for the residents with confusion, the IP was unable to explain the reason why the residents assessed with confusion was identified as asymptomatic on the log. The IP verified the residents with increased confusion were documented as asymptomatic. The IP was informed and verified the above findings. Cross reference to F880, examples #2 and #3.