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	04/24/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents reviewed for unnecessary medications (Residents 2, 4, 11, 75, and 95) and one final sampled resident (Resident 13) reviewed for informed consents were provided the right to self-determination regarding the use of psychotropic medications and treatments. * The facility failed to ensure the informed consents for the quetiapine (antipsychotic) and mirtazapine (antidepressant) medications included the indication of use and manifested behavior for Resident 2. * The facility failed to ensure the informed consent for the quetiapine medication included the indication for the use and manifested behavior for Resident 4. * The facility failed to ensure the informed consent for the mirtazapine medication included the indication for the use and manifested behavior for Resident 11. * The facility failed to ensure the informed consent for the lorazepam (antianxiety) medication included the indication for the use and manifested behavior for Resident 13. * The facility failed to ensure the informed consents for the Seroquel (antipsychotic) and valproic acid (anticonvulsant used to treat bipolar disorder) medications included the indication for the use and manifested behaviors Resident 75. * The facility failed to ensure the informed consents for the quetiapine medication and zolpidem tartrate (sleep aid) medications included the indication for the use and manifested behavior for Resident 95. These failures posed the risk of the residents and their responsible party of not understanding the clinical rationale, expected benefits, or behavioral indications for the psychotropic medications being administered.Findings: Review of the AFL 25-27 titled AB 48 – Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information that the provider shall provide includes but is not limited to: - Possible nonpharmacologic approaches that could address the resident's needs; - Whether the drug has a current boxed warning label along with a summery of, and information about how to find, the contraindications, warnings, and precautions required by the United States FDA; - Whether the proposed drug is being prescribed for a purpose that has or has not been approved by the United States FDA; - Possible interactions with other drugs the resident is receiving; and - How the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. (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
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1, titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 10/7/25, showed effective 1/1/26, the Psychotherapeutic Drug Informed Consent Form or equivalent in-house form must be used for new residents, residents being prescribed a new psychotherapeutic drug, or residents having a psychotherapeutic drug dosage change. The Psychotherapeutic Drug Informed Consent Form Instruction Sheet showed the form will be completed by. entering the drug category and. providing the use and benefits of the psychotherapeutic drug. Review of the facility's P&P titled Use of Psychotropic Medication revised 11/2025 showed the indications for initiation, withdrawing, or withholding medication(s), shall be determined by: assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences, and goals for treatment, and identification of underlying causes, if possible. 1. Medical record review for Resident 2 was initiated on 4/21/26. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed the following physician's orders dated: - 3/11/26, to administer mirtazapine 7.5 mg by mouth at bedtime for depression manifested by poor oral intake; and - 9/15/25, to administer quetiapine 50 mg by mouth at bedtime for psychosis manifested by paranoid delusion. Review of Resident 2's Psychotherapeutic Drug Informed Consent for quetiapine medication dated 1/28/26, did not show the reason for use or behavior manifestation related to the use of quetiapine was included consent form. Review of Resident 2's Psychotherapeutic Drug Informed Consent for Remeron (mirtazapine) medication dated 3/5/26, did not show the reason for use or behavior manifestation related to the use of mirtazapine was included in the consent form. Review of Resident 2's MAR for April 2026 showed Resident 2 was administered the mirtazapine and quetiapine medications from 4/1 to 4/22/26 at 2100 hours. On 4/23/26 at 1115 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 2. RN 2 verified the informed consent forms did not include the indication for use or the behavior manifestations related to the use of the mirtazapine and quetiapine medications for Resident 2. 2. Medical record review for Resident 11 was initiated on 4/21/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed a physician's order dated 3/24/26, to administer mirtazapine 15 mg by mouth at bedtime for depression manifested by poor oral intake. Review of Resident 11's Psychotherapeutic Drug Informed Consent for mirtazapine medication dated (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/24/26, did not show the reason for use or behavior manifestation related to the use of the mirtazapine medication was included in the consent form. Review of Resident 11's MAR for April 2026 showed Resident 11 was administered the mirtazapine and quetiapine medications from 4/1 to 4/21/26 at 2100 hours. On 4/23/26 at 1114 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 2. RN 2 verified the informed consent form did not include the indication for use or the behavior manifestation related to the use of the mirtazapine medication for Resident 11. 3. Medical record review for Resident 13 was initiated on 4/21/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed a physician's order dated 2/2/26, to administer lorazepam 0.5 mg via GT two times a day for anxiety manifested by physical restlessness causing distress. Review of Resident 13's Psychotherapeutic Drug Informed Consent for lorazepam medication dated 2/2/26, did not show the reason for use or behavior manifestation related to the use of the lorazepam medication was included in the consent form. Review of Resident 13's MAR for April 2026 showed Resident 13 was administered the lorazepam medication from 4/1 to 4/21/26 at 0900 and 1700 hours, and on 4/22/26 at 0900 hours. On 4/23/26 at 1051 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the informed consent form did not include the indication for use or the behavior manifestations related to the use of the lorazepam medication for Resident 13. On 4/23/26 at 1340 hours, an interview for Residents 2, 11 and 13 was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Medical record review for Resident 4 was initiated on 4/21/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 3/31/26, to administer quetiapine 25 mg one tablet by mouth two times a day for psychosis as manifested by striking out during care. Review of Resident 4's Psychotherapeutic Drug Informed Consent for quetiapine medication dated 3/31/26, did not show the reason for use or behavior manifestation related to the use of the quetiapine medication was included in the consent form. Review of Resident 4's MAR dated 4/1 to 4/30/26, showed Resident 4 was administered the quetiapine medication from 4/1 to 4/22/26 at 0900 and 1700 hours. On 4/23/26 at 0930 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 verified the informed consent forms did not include the indication for use or the behavior manifestations related to the use of the quetiapine medications for Resident 4. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/26 at 1058 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 5. Medical record review for Resident 75 was initiated on 4/23/26. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's H&P examination dated 4/9/26, showed Resident 75's diagnoses included chronic dementia with agitation. The H&P showed Resident 75 could make her needs known. Review of Resident 75's MAR for April 2026 showed Resident 75 was administered Seroquel 25 mg twice daily for psychosis manifested by striking out and valproic acid 2.5 ml twice daily as a mood stabilizer for manifestations of sudden yelling out loud; attention seeking. Review of Resident 75's informed consents for the Seroquel medication dated 2/5/26, and for valproic acid medication dated 3/24/26, failed to include the indication for the use and manifested behavior for both medications. On 4/24/2026 at 1005 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 2. MDS 2 Coordinator 2 was informed and verified the above findings. 6. Medical record review for Resident 95 was initiated on 4/23/26. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's Order Summary Report showed the following physician's orders dated: - 3/27/26, to administer quetiapine 50 mg by mouth at bedtime for psychosis manifested by visual hallucination seeing things that is not real; and - 3/27/26, to administer zolpidem tartrate 10mg by mouth at bedtime for insomnia manifested by inability to sleep. Review of Resident 95's Psychotherapeutic Drug Informed Consent for quetiapine medication dated 3/27/26, did not show the reason for use or behavior manifestation related to the use of quetiapine was included in the consent form. Review of Resident 95's Psychotherapeutic Drug Informed Consent for zolpidem tartrate medication dated 3/27/26, did not show the reason for use or behavior manifestation related to the use of the zolpidem tartrate medication was included in the consent form. Review of Resident 95's MAR for April 2026 showed Resident 95 was administered the quetiapine and zolpidem medications from 4/1 to 4/22/26 at 2100 hours. On 4/23/26 at 1512 hours, an interview and concurrent medical record review for Resident 95 was conducted with RN 2. RN 2 verified the informed consent forms did not include the indication for use or the behavior manifestations related to the use of the quetiapine and zolpidem medications for Resident 95.

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the respiratory care and services were provided in accordance with the professional standards for two of three final sampled residents (Residents 57 and 83) reviewed for respiratory care. * The facility failed to ensure Resident 57's nasal cannula was placed properly positioned and the oxygen concentrator was functioning properly. * The facility failed to ensure Resident 83's Yankauer suction tubing was labeled. These failures had the potential to result in the residents not receiving appropriate respiratory care and increased risks of the infection.Findings: 1. Medical record review for Resident 83 was initiated on 4/21/26. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed a physician's order dated 4/14/26, to suction secretions as needed for excessive secretions. On 4/21/26 at 0915 hours, Resident 83 was observed lying in his bed. The Yankauer suction tubing was observed open, connected to the suction machine, and stored inside the original packaging in the resident's partially open bedside drawer. The Yankauer suction tubing was labeled. On 4/21/26 at 0918 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the Yankauer suction tubing for Resident 83 was not labeled. LVN 1 stated she could not verify when the Yankauer suction tubing was last changed. LVN 1 stated the Yankauer suction tubing should have been labeled. On 4/24/26 at 1058 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. According to the manufacturer's Invacare Perfecto2 Oxygen Concentrator Service Manual dated 10/19/16, under Section 10.2 O2 Indicators, a general warning symbol (consisting of an exclamation point inside a triangle) was shown when the oxygen purity levels were between 73 to 85%, and the yellow indicator lights signify device failure. The user manual instructs the staff to call a qualified technician and to initiate a back-up oxygen supply. Review of the facility's P&P titled Oxygen Administration revised 10/2010 under Steps in the Procedure section, showed the following: - Check the mask, task, humidifying jar, etc., to be sure they are in good working order and are securely fastened; and - Observe the resident upon set-up and periodically thereafter to be sure oxygen is being tolerated. On 4/21/26 at 0911 and 1217 hours, Resident 57 was observed asleep in bed and receiving two liters per minute of oxygen via nasal cannula. An audible alarm was observed sounding from the oxygen concentrator. The display panel showed a general warning symbol and a phone icon. Medical record review for Resident 57 was initiated on 4/21/26. Resident 57 was admitted to the facility on [DATE]. (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 57's Order Summary Report showed a physician's order dated 1/24/26, to administer the oxygen at two liters per minute via nasal cannula continuously every shift for shortness of breath to maintain oxygen saturation more than 95%. On 4/21/26 at 1230 hours, Resident 57 was observed awake, seated near the bed, and assisted with feeding by CNA 1. Resident 57 was receiving two liters per minute of oxygen via nasal cannula, and an audible alarm was observed sounding from the oxygen concentrator. CNA 1 verified the audible alarm was coming from the oxygen concentrator. On 4/21/26 at 1601 hours, Resident 57 was observed asleep in bed. The nasal cannula connected to the oxygen concentrator was observed not properly positioned in the resident's nostrils. The oxygen concentrator in use was actively emitting an audible alarm. The display panel showed a general warning symbol and a phone icon. On 4/21/26 at 1604 hours, an observation for Resident 57 and concurrent interview was conducted with LVN 5 and RN 3. LVN 5 verified Resident 57's nasal cannula was not properly positioned in the resident's nostrils, and the oxygen concentrator in use was actively emitting an audible alarm with the display panel showing a general warning symbol and a phone icon. LVN 5 was observed placing the nasal cannula on the resident's nostrils. LVN 5 was asked to check Resident 57's oxygen saturation, and Resident 57's oxygen saturation was at 95 to 96% on two liters per minute of oxygen. LVN 5 stated she was not aware whether a technician had been contacted and that the concentrator would need to be replaced. RN 3 was observed replacing the oxygen concentrator. On 4/23/26 at 1340 hours, an interview for Resident 57 was conducted with the Administrator and DON. The DON and the Administrator were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the residents were free from unnecessary medications for one of five sampled residents reviewed for unnecessary medications (Resident 11) and two of 19 final sampled residents (Residents 13 and 57). * The facility failed to ensure Resident 57's heart rate was monitored prior to administering the amlodipine (blood pressure medication) and lisinopril (blood pressure medication), as prescribed by the physician. * The facility failed to ensure Resident 13's heart rate was monitored prior to administering the diltiazem (blood pressure medication) and hydralazine (blood pressure medication), as prescribed by the physician. * The facility failed to ensure Resident 11's heart rate was monitored prior to administering the amlodipine (blood pressure medication), as prescribed by the physician. These failures placed the residents at risk for the adverse medication side effects when the ordered parameters were not followed and had the potential to negatively affect the residents' health and wellˆbeing.Findings: 1. Medical record review for Resident 57 was initiated on 4/21/26. Resident 57 was admitted to the facility on [DATE]. Review of Resident 57's Order Summary Report showed the following physician's orders dated 3/27/26:- To administer amlodipine besylate 10 mg by mouth in the morning for hypertension and to hold if the systolic blood pressure less than 110 mmHg, and heart rate less than 60 beats per minute; and- To administer lisinopril 20 mg one time a day for hypertension, and to hold if the systolic blood pressure less than 110 mmHg, and heart rate less than 60 beats per minute. Review of Resident 57's MAR for April 2026 showed Resident 57 was administered the amlodipine and lisinopril medications from 4/1 to 4/22/26 at 0900 hours. However, there was no documented evidence to show the licensed nurses monitored Resident 57's heart rate prior to the administration of the amlodipine and lisinopril medications. On 4/22/26 at 1520 hours, an interview and concurrent medical record review for Resident 57 was conducted with RN 2. RN 2 verified the above findings. 2. Medical record review for Resident 13 was initiated on 4/21/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed the following physician's orders dated 3/27/26:- To administer diltiazem 60 mg via GT every eight hours for hypertension, and to hold if the systolic blood pressure less than 110 mmHg, and heart rate less than 60 beats per minute; and- To administer hydralazine 100 mg via GT every eight hours for hypertension, and to hold if the systolic blood pressure less than 110 mmHg, and heart rate less than 60 beats per minute. Review of Resident 13's MAR for April 2026 showed Resident 57 was administered the diltiazem and hydralazine medications from 4/1 to 4/22/26 at 0600, 1400, and 2200 hours. However, there was no documented evidence to show the licensed nurses monitored Resident 13's heart rate prior to the administration of the diltiazem and hydralazine medications. On 4/22/26 at 1608 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the above findings. 3. Medical record review for Resident 11 was initiated on 4/21/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed a physician's order dated 3/27/26, to administer amlodipine besylate 2.5 mg one time a day for hypertension, and to hold if the systolic blood pressure less than 110 mmHg, and heart rate less than 60 beats per minute. Review of Resident 11's MAR for April 2026 showed Resident 11 was administered the amlodipine medication from 4/1 to 4/22/26 at 0900 hours. However, there was no documented evidence to show the licensed nurses monitored Resident 11's heart rate prior to the administration of the amlodipine medication. On 4/22/26 at 1505 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 2. RN 2 verified the above findings. On 4/23/26 at 1340 hours, an interview for Residents 11, 13, and 57 were conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged 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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain sanitary conditions in the kitchen and food storage areas. * Red tape marking the food-preparation area was placed too far inward, allowing staff and visitors access to milk without wearing required hair restraints. * One cup of milk was uncovered and contained a black particle floating on the surface. * A hair restraint was not worn to cover Maintenance Supervisor's chin beard while inside the kitchen. * A dusty portable fan was blowing air into the storage rack containing clean plate lids. * Two cutting boards in the food preparation area were heavily marred. * Brownish particles were observed inside the oven, located between two glass casings. * A 70% vegetable oil container stored inside the walk-in refrigerator was not labeled with an open date. These failures posed a risk of food borne illness to the 86 of 94 residents who received food from the kitchen. Findings: Review of the facility's April 2026 Diet Type Report showed a total of 86 of 94 residents received meals prepared inside the facility's kitchen. a. On 4/21/26 at 0743 hours, during an initial tour of the facility's kitchen with the DSS, the following was observed: - Two cutting boards were heavily marred with white discoloration.- Brownish particles were observed inside the oven.- A vegetable oil spread plastic container in the walk-in refrigerator was not labeled with an open date.The DSS verified the above findings and acknowledged the oven should have been clean and the plastic container should have been labeled with an open date. b. According to the FDA food code 2022, 2-103.11(B), person in charge shall ensure that persons unnecessary to the food establishment operation are not allowed in the food preparation areas unless steps are taken to ensure exposed foods are protected from contamination. On 04/21/26 at 1038 hours, during an observation of the facility's kitchen, red duct tape marking the milkˆserving preparation area was observed positioned in a way that allowed entry into the area. Two family members without hairnets were within the enclosed area where Dietary Aide 2 was pouring milk into open plastic cups. One open cup was observed with a black particle floating on top of the milk. Dietary Aide 2 verified the milk was to be served to residents. Dietary Aide 2 verified there was a black particle floating on top of the milk served in one of the cups. The DSS verified the above findings and acknowledged the placement of the red tape allowed visitors to access resident food without hair restraints. c. According to the FDA food code 2-402.11 (A), beard restraints are worn to keep hair from contaminating exposed food and clean equipment. On 4/22/26 at 930 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor was observed with a chin beard and walking past the kitchen refrigerators without a beard restraint. The Maintenance Supervisor and DSS acknowledged the Maintenance Supervisor should have worn a beard restraint before entering the kitchen. d. According to the FDA code, 4-903.11(A)(2) Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, clean equipment shall be stored where it is not exposed to dust or other contamination. On 4/22/26 at 1050 hours, during an observation of the facility's kitchen and concurrent interview with the DSS, a portable fan measuring approximately two feet in diameter was observed blowing air toward a rack of clean, dry plate lids. [NAME] particles were observed on the fan's grill. The DSS verified the findings. On 4/23/26 at 1100 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the above findings.

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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** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices. * The facility failed to ensure the staff members' personal items were not stored in the clean linen area. * The facility failed to conduct a facility-wide risk assessment to identify areas where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread within the facility water system. * The facility failed to protect the residents' clean personal clothing from dust and contamination during transport and Laundry Aide 2 failed to performed hand hygiene when entering and leaving EBP rooms. * The facility failed to ensure CNA 3 donned PPE when changing the linen for Resident 13, who was on EBP. These failures posed the risk of infection and the transmission of disease-causing microorganisms to highly vulnerable residents.Findings: 1. On 4/23/26 from 1024 to 1037 hours, an interview and concurrent observation was conducted with Laundry Aide 1 in the laundry room. A black vest was observed hanging on a clothing hook in the clean linen sorting area, touching the sorting gowns. Laundry Aide 1 verified the sorting gowns were clean and stated the black vest belonged to a staff member who was not there today to remove it. On 4/23/26 at 1319 hours, an interview was conducted with the Housekeeping Supervisor. The Housekeeping Supervisor verified the above findings and stated the vest should not have been in the clean linen area, and the staff had an employee lounge where personal items could be stored. 2. Review of the facility's P&P titled Legionella: Water Management Program Policy revised 8/28/25, showed the facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. Further review of the P&P showed the identification of the situation that can lead to Legionella growth, such as: Construction; Water main breaks; Changes in municipal water quality; The presence of biofilm, scale or sediment; Water temperature fluctuations; Water pressure changes; and, Water stagnation; and inadequate disinfection. Review of CMS Quality, Safety and Oversight Group guidance titled Requirement to Reduce Legionella Risk in Healthcare Facility Water System to Prevent Cases and Outbreaks of Legionnaires' Disease revised 7/6/18, showed facilities must, at a minimum: (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread. - Develop and implement a water management program that considers ASHRAE standards and the CDC toolkit. - Specify testing protocols, acceptable control measure ranges, and document testing results and corrective actions. Review of the facility's document titled Water System Flow Diagram (undated) showed the following: - The receiving water and the fireˆsuppression sprinkler system in the kitchen were coded blue. - The coldˆwater distribution system supplying the kitchen ice machine, sinks and showers in residentˆcare areas, fountain, sprinklers, water softener and laundry was coded green. - The heating components, including the kitchen and laundry water heaters and the water heaters serving sinks and showers in residentˆcare areas, were coded in a light orange color. - The hotˆwater distribution system supplying kitchen appliances, sinks, the dishwasher, residentˆcare area sinks and showers, and laundry washing machines, was coded in a dark orange color. - The sanitary sewer system was coded red. However, further review of the facility's documents related to Legionella and other opportunistic waterborne pathogens did not show evidence the facility completed a comprehensive risk assessment identifying where pathogens could grow and spread within the water system. On 4/24/26 at 1106 hours, an interview and concurrent facility document review was conducted with the IP and Maintenance Supervisor. When the IP and Maintenance Supervisor were asked if the facility had a risk assessment that had been completed to identify where Legionella or other opportunistic waterborne pathogens could grow and spread, the IP and Maintenance Supervisor kept referring to the page titled instructions on what the Maintenance Supervisor visually checked. On 4/24/26 at 1344 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the facility did not have documentation to show how the facility identified hazardous areas within the water system where opportunistic pathogens could grow. On 4/24/26 at 1424 hours, an interview was conducted with the IP Consultant. The IP Consultant verified the facility did not have documentation to show a risk assessment for Legionella had been completed, other than the map of the waterflow. On 4/24/26 at 1500 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. According to CDC: - Under the Linen and Laundry Management section dated 9/19/24, the best practices for (continued on next page)

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	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management of clean linen included sorting, packaging, transporting, and storing clean linen in a manner that prevents risk of contamination by dust, debris, soiled linen or other soiled linen; and - Under Implementation of PPE Use in Nursing Homes to Prevent Spread of MDRO dated 4/2/24, prevention of MDRO transmission in nursing homes requires more than just proper use of PPE and room restriction. Guidance included implementing other recommended infection prevention practices such as hand hygiene. The EBP sign showed everyone must clean their hands, including before entering and when leaving the room. Review of the facility's P&P titled Laundry and Bedding, Soiled revised 10/2018 under Transport section, showed clean linens are protected from dust and soiled during transport and storage to ensure cleanliness. On 4/21/26 at 0945 hours, during the initial tour of the facility, multiple residents' personal clothing items were observed hanging on a partially covered mobile rack being pushed down the hallway by a laundry aide, leaving the clothing items visibly exposed. On 4/22/26 at 0941 hours, multiple residents' personal clothing items were observed hanging on a partially covered mobile rack being pushed along the hallway by Laundry Aide 2 The mobile rack was then parked near the nurses' station, leaving the clothing items visibly exposed. Furthermore, Laundry Aide 2 was observed entering and leaving Rooms A and B without performing hand hygiene. Rooms A and B were observed with orange precautions signs posted outside the rooms, alerting everyone entering and leaving the room to perform hand hygiene. On 4/22/26 at 0945 hours, an observation of the laundry rack, Rooms A and B, and concurrent interview was conducted with Laundry Aide 2. Laundry Aide 2 verified the clothing rack was partially covered, which left the clothing items visibly exposed. Laundry Aide 2 stated she left the clothing rack uncovered because it was easier to look at the labels on the residents' personal clothing and the room numbers. Laundry Aide 2 verified she did not perform hand hygiene when entering and leaving Rooms A and B, which were on EBP. On 4/22/26 at 0955 hours, an observation of Rooms A and B and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he helped oversee the laundry when the Housekeeping Supervisor was not available. The Maintenance Supervisor stated the laundry mobile rack should be covered at all times when the residents' clothing items were being transported along the facility hallway. The Maintenance Supervisor verified Rooms A and B were observed with orange precautions signs posted outside the rooms, alerting everyone entering and leaving the room to perform hand hygiene. The Maintenance Supervisor stated the laundry aides should perform hand hygiene when entering and leaving the rooms on EBP. 4. According to CDC: - Under the Linen and Laundry Management section dated 9/19/24, the best practices for linen and laundry handling included always wearing rubber gloves before handling soiled linen such as bed sheets, towels and curtains; and - Under Frequently Asked Questions about EBP in Nursing Homes dated 6/28/24, changing linen is considered a high contact resident care activity, gowns and gloves should be worn if changing the linen of residents on EBP and could be considered for additional environmental services that involve (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

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Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extensive contact with the resident or the resident's environment. On 4/22/26 at 1025 hours, Resident 13 was not observed in the room, and an EBP sign was observed posted outside Resident 13's room alerting the providers and staff to wear gloves and a gown for high-contact resident care activities such as changing linen. CNA 3 was observed in the room changing the resident bed linen. CNA 3 was not observed wearing any gloves or gown. Then after changing the bed linen, CNA 3 was observed using the alcohol-based hand rub and left the room. On 4/22/26 at 1051 hours, an observation for Resident 13 and a concurrent interview was conducted with CNA 3. CNA 3 verified she did not wear any PPE such as gloves and gown while changing the resident bed linen. CNA 3 stated I made the bed without gown and gloves because the resident was not in the room. Medical record review for Resident 13 was initiated on 4/21/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed a physician's order dated 7/9/25, to place Resident 13 on EBP due to the presence of PEG tube. On 4/23/26 at 1319 hours, an interview was conducted with the IP. The IP stated everyone, including the laundry staff, must perform hand hygiene, such as using the hand sanitizer, when entering and leaving the room on EBP. The IP also stated CNAs should wear PPE such as gown and gloves when changing the linen for the residents on EBP, because the residents were at high risk of infection, and could have contaminated the resident's linen. The IP stated the CNAs could expose their uniforms to the soiled resident linen and spread infection once they leave the resident room on EBP. On 4/23/26 at 1340 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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	056271	A. Building B. Wing	04/24/2026

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide a reasonable accommodations to meet the needs of one of 19 final sampled residents (Resident 108). * The facility failed to ensure Resident 108's call light was within the resident's reach. This failure had the potential to negatively impact the resident's psychosocial well-being and cause delays in receiving needed care.Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 10/2025 showed the purpose of the policy is to assure the facility is adequately equipped with a call light at each resident's bed side, toilet, and bathing facility to allow resident to call for assistance. Call light will directly relay to a staff member or centralized location to facilitate appropriate response. Staff should facilitate call light placement within reach of resident and secure it as needed. The call system should be accessible to residents when in bed or other sleeping accommodations in room. On 4/21/26 at 0840 hours, Resident 108 was observed seated in a wheelchair on the right side of her bed. The resident's call light button was observed hanging on the right side of the bed but positioned on the left side of the resident's wheelchair. On 4/21/26 at 0846 hours, the Activity Assistant was called to the room, and an observation and concurrent interview was conducted with Resident 108, with translation provided by the Activity Assistant. Resident 108 stated she was unable to move the left arm and required staff assistance for activities of daily living. Resident 108 also reported that she used the call light button to request for staff assistance. During the observation, Resident 108 was observed searching for her call light button using her right hand. The call light was located hanging on the bed on the left side of the resident. Resident 108 attempted to reach the call light with her right hand but was unable to do so. The call light was not within her reach while she was seated in her wheelchair on the right side of the bed. The Activity Assistant verified the call light was not within reach of the resident and was observed placing the call light within the resident's reach. Medical record review for Resident 108 was initiated on 4/21/26. Resident 108 was admitted to the facility on [DATE]. Review of Resident 108's Physical Therapy Evaluation and Plan of Treatment dated 4/20/26, showed Resident 108 had impaired ROM in the right and left lower extremity. Review of Resident 108's Occupational Therapy Evaluation and Plan of Treatment dated 4/20/26, showed Resident 108's had impaired ROM in the left upper extremity. Review of Resident 108's H&P examination dated 4/21/26, showed Resident 108 was able to make medical decisions and needs known. On 4/24/26 at 1058 hours, an interview was conducted with the Administrator and DON. The DON stated the call lights should be within the reach of all residents. The Administrator and DON were informed and acknowledged the above findings.

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	056271	A. Building B. Wing	04/24/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the written information and follow^up assistance regarding the formulation of an advance directive for one of three final sampled residents (Resident 95) reviewed for advanced directives. * The facility failed to provide Resident 95 with written information on how to formulate an advanced directive. In addition, the facility failed to follow up and assist Resident 95 in completing an advanced directive. This failure had the potential for Resident 95 to receive care or emergency treatment that did not align with the resident's expressed wishes.Findings: Medical record review for Resident 95 was initiated on 4/22/26. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 3/28/26, showed Resident 95 had the capacity to understand and make decisions. Review of Resident 95's Advance Directives Acknowledgment dated 3/29/26, showed the resident had capacity, and would like assistance to formulate an advance directive. Further review of Resident 95's medical record failed to show the documented evidence the facility provided the resident with written information or followed up to assist the resident in completing an advance directive. On 4/22/26 at 0955 hours, an interview and concurrent medical record review for Resident 95 was conducted with the SSD. The SSD stated the admission nurse completed the Advance Directives Acknowledgment form and the social services was responsible for follow^up. The SSD stated if a resident requested assistance, the social services should provide written information, document the information provided, and follow up within 1-2 (one to two) weeks to assist with formulating the advance directive. The SSD stated it had been three weeks since the resident's admission to the facility and was unsure whether a follow^up had occurred, but verified there was no documentation in the medical record to show if information was provided or assistance was offered. On 4/22/26 at 1008 hours, an interview was conducted with Family Member (FM) 1. FM 1 stated she did not receive any paperwork or information regarding how to formulate an advanced directive for Resident 95. On 4/24/26 at 1131 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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	056271	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 2 and 11) were free from unnecessary psychotropic medication. * The facility failed to ensure accurate monitoring of meal intake related to the use of mirtazapine (antidepressant) for Residents 2 and 11. This failure had the potential to result in unnecessary medication use and ineffective monitoring for the use of psychotropic medications, which could negatively affect the well-being of Residents 2 and 11.Findings: 1. Review of the facility's P&P titled Use of Psychotropic Medication revised 11/2025 showed the effects of the psychotropic medications on a resident's physical, mental, psychosocial well-being shall be evaluated on an ongoing basis, such as.in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care. Medical record review for Resident 11 was initiated on 4/21/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed the following physician's orders:- dated 3/24/26, to administer mirtazapine 15 mg one tablet by mouth at bedtime for depression manifested by poor oral intake less than 76%.- dated 7/29/24, to monitor and record meal percentages for breakfast, lunch and dinner, for mirtazapine use; and Review of Resident 11's MAR for April 2026 showed the following:- the mirtazapine medication was administered from 4/1 to 4/21/26 at 2100 hours; and- Resident 11's meal intake for dinner was 90% on 4/8 and 4/16/26, and meal intake for lunch was 50% on 4/19/26. Review of Resident 11's CNA documentation, under Nutrition - Amount Eaten section for April 2026 showed Resident 11 consumed 51 to 75% for dinner on 4/8 and 4/16/26 and consumed 76 to 100% for lunch on 4/19/26. On 4/22/26 at 1505 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 2. RN 2 stated the licensed nurses documented the resident's meal intake in the MAR based on information provided by the CNAs. RN 2 verified the MAR documentation by the licensed nurses did not match the CNA documentation in the Task records for Resident 11. 2. Medical record review for Resident 2 was initiated on 4/21/26. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed the following physician's orders:- dated 3/9/26, to monitor oral intake less than 76% and refusal of meals during mealtime, and document episodes of refusals, for mirtazapine use; and - dated 3/11/26, to administer mirtazapine 15 mg one tablet by mouth at bedtime for depression manifested by poor oral intake less than 76%. Review of Resident 2's MAR for April 2026 showed the following:- the mirtazapine medication was administered from 4/1 to 4/22/26 at 2100 hours; and- Resident 2's meal intake for dinner was 50% on 4/8 and 4/10/26, and meal intake for lunch was 20% on 4/19/26. Review of Resident 2's CNA documentation, under Nutrition - Amount Eaten section for April 2026 showed Resident 2 consumed 76 to 100% for dinner on 4/8/26; 51 to 75% for dinner on 4/10/26, and 76 to 100% for lunch on 4/19/26. On 4/23/26 at 1115 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 2. RN 2 verified the meal intake documentation in the MAR by the licensed nurses did not match the CAN Task documentation for Resident 2. On 4/23/26 at 1340 hours, an interview for Residents 2 and 11 was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	056271	A. Building B. Wing	04/24/2026

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Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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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, medical record review, and facility P&P review, the facility failed to provide a copy of the notification of the transfer/discharge to the Office of the State Long-Term Care Ombudsman for one of the three residents (Resident 105) reviewed for closed records. * The facility failed to ensure copy of the transfer discharge notification was sent to the Ombudsman when Resident 105 was transferred to the acute care hospital. This failure had the potential to result in the resident not receiving accurate information regarding transfer/discharge status and the right to appeal.Findings: Review of the facility's P&P titled Transfer or Discharge Notice revised December 2016 showed in part, the notice will be given as soon as it is practicable but before the transfer or discharge: a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility;b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; andc. The safety of individuals in the facility is endangered.The resident and/or representative (sponsor) will be notified in writing of the following information:a. The reason for the transfer or discharge.b. The effective date of the transfer or discharge.c. The location to which the resident is being transferred or discharged .d. A statement of the resident's rights to appeal the transfer or discharge, including: (1) the name, address, email and telephone number of the entity which receives such requests. (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process.e. The facility bed-hold policy.f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman.A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.The reasons for the transfer or discharge will be documented in the resident's medical record. Closed medical record review for Resident 105 was initiated on 4/23/26. Resident 105 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 3/7/26. Review of Resident 105's Physician Order Summary showed a physician's order dated 3/7/26, to transfer Resident 105 to the acute care hospital for further evaluation due to poor oral intake, and generalized weakness. However, further review of Resident 105's medical record failed to show documented evidence that the Ombudsman was notified of Resident 105's transfer to the acute care hospital. On 4/23/26 at 1120 hours, an interview and concurrent closed medical record review for Resident 105 was conducted with RN 1. RN 1 stated she would look for a copy of the fax transmittal or other documentation to show the Ombudsman notification. On 4/23/26 at 1335 hours, follow up interview was conducted with RN 1. RN 1 stated the copy of the Ombudsman of Resident 105's transfer should be in a binder with the other fax transmittals, however, RN 1 verified there was no documentation to show the Ombudsman was notified of Resident 105's transfer to the acute care hospital. On 4/24 26 at 1424 hours, an interview was conducted with the DON. The DON was informed and verified the findings. The DON stated the facility had a system in place to notify the Ombudsman but missed that one.

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	04/24/2026

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Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop a comprehensive person-centered care plan for one of 19 final sampled residents (Resident 5). * The facility failed to develop a care plan problem to address Resident 5's use of LAL mattress with bolster (a medicalˆgrade mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup, with raised foam edges to support positioning and prevent rolling out of bed). This failure posed the risk of not providing appropriate, consistent, and individualized care for Resident 5.Findings: Review of the facility's P&P titled Comprehensive Assessments and the Care Delivery Process revised 12/2016 showed in part, comprehensive assessments will be conducted to assist in developing person -centered care plans. Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. The objective of the information collection phase is to obtain, organize, and subsequently analyze information about the patient. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation from other health professionals. Completed assessments are maintained in the resident's active record for a minimum of 15 months. These assessments are used to develop, review and revise the resident's comprehensive care plan. Medical record review for Resident 5 was initiated on 4/24/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report dated 4/24/26, showed a physician's order dated 4/3/26, for a LAL mattress in bed every shift for skin management. Review of Resident 5's plan of care failed to show any care plan problem, foal or intervention addressing the use of the LAL mattress with bolster. On 4/24/26 at 1030 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 2. Resident 5's use of the low air loss mattress for skin maintenance and the bolster for positioning to prevent the resident from rolling out of bed. LVN 2 verified that no care plan had been developed to address this equipment. On 4/24/26 at 1045 hours, an interview was conducted with RN 2. RN 2 verified there was no care plan developed for Resident 5's use of the LAL mattress with bolster. On 4/24/26 at 1423 hours, an interview was conducted with the DON. The DON verified there was no care plan developed for Resident 5's use of the LAL mattress with bolster.

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	056271	A. Building B. Wing	04/24/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to revise the comprehensive, person-centered care plan for three of 19 final sampled residents (Residents 5, 11, and 87). * The facility failed to revise Resident 5's care plan when the order for Foley Catheter (a thin, flexible, indwelling tube inserted through the urethra - a tube that transports urine from the bladder to the opening of penis in male and vulva in female, into the bladder to drain urine into a bag, held in place by a small balloon) was discontinued. This posed the risk of not providing the resident with individualized and person-centered care. * The facility failed to revise the plan of care for Residents 11 and 87 to address the adjustments to the APP mattress settings made for the residents' comfort. This failure had the potential to result in inconsistent interventions and place the residents at risk for inadequate pressure redistribution and skin breakdown.Findings: 1. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 12/2016 showed the following: - Comprehensive, person-centered care plan will.describe services that otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.incorporate identified problem areas, incorporate risk factors associated with identified problems.reflect the resident's expressed wishes regarding care and treatment goals.and aid in preventing or reducing decline in the resident's functional status and/or functional levels; and - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of the manufacturer's APP and Bubble Pad User Manual (undated) showed to use the pressure adjustable knob to give maximum resident comfort. On 4/21/26 at 0933, 1222, and 1557 hours, Resident 87 was observed lying in bed, with an APP machine attached to the foot board of the bed. The APP mattress setting was observed at 180. Medical record review for Resident 87 was initiated on 4/21/26. Resident 87 was readmitted to the facility on [DATE]. Review of Resident 87's Order Summary Report showed a physician's order dated 3/14/26, to provide APP mattress in bed for skin management. Review of Resident 87's Weight Summary Report showed Resident 87 weighed 101 lbs. for the week of 4/8, and 4/22/26. Review of Resident 87's plan of care showed a care plan problem initiated on 7/20/24, to address the resident's risk for skin breakdown. The interventions included APP mattress in bed. On 4/22/26 at 1424 hours, Resident 87 was observed lying in bed, with an APP machine attached to the foot board of the bed. The APP machine setting was observed at 280. On 4/22/26 at 1425 hours, an observation for Resident 87 and concurrent interview was conducted (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with CNA 1. CNA 1 verified Resident 87 was in bed, with the APP mattress setting at 280. CNA 1 stated she did not adjust the APP setting. CNA 1 stated the CNAs reported to the treatment nurse if they had problems with the APP mattress. On 4/22/26 at 1439 hours, an observation for Resident 87, interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 87 was in bed, with the APP mattress setting at 280. LVN 2 stated the APP mattress setting maybe adjusted based on the resident's comfort. LVN 2 further verified Resident 87's plan of care was not revised to reflect these adjustments or include monitoring or evaluating the effectiveness. Cross-reference to F729, example #2. 2. Review of the manufacturer's Alternating Pressure Relief System User Manual (undated) showed the product is intended to help and reduce the incidence of pressure ulcers while optimizing resident comfort. On 4/22/26 at 1430 hours, an observation for Resident 11 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 11 was in bed, with the APP mattress set to firm. On 4/22/26 at 1440 hours, an observation for Resident 11, interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 11 was in bed, with the APP mattress setting at 280. LVN 2 stated the APP mattress setting maybe adjusted based on the resident's comfort. LVN 2 further verified Resident 11's plan of care was not revised to reflect these adjustments or include monitoring or evaluating their effectiveness. On 4/23/26 at 1340 hours, an interview for Residents 11 and 87 was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 5 was initiated on 4/24/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's physician's order dated 3/27/26, showed to D/C (discontinue) the Foley catheter today. On 4/24/26 at 1315 hours, an observation for Resident 5 and concurrent interview was conducted with LVN 2. LVN 2 verified Resident 5 no longer had an indwelling urinary Foley catheter and stated she removed it on 3/27/26. On 4/24/26 at 1330 hours an interview and concurrent medical record review for Resident 5 was conducted with RN 2. RN 2 verified the comprehensive care plan continued to show Resident 5 had an indwelling urinary Foley catheter and that it should have been revised upon removal. On 4/24/ 26 at 1422 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. The DON verified the care plan was not revised when the indwelling urinary Foley Catheter was discontinued.

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	04/24/2026

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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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, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of 19 final sampled residents (Resident 5). * The facility failed to identify and notify the physician and the resident's representative of Resident 5's eye redness with discharge. In addition, the facility failed to ensure the dark purplish discoloration on the resident's right dorsal (back side) hand and the light purplish discoloration on the left posterior lower arm were monitored and reported to the physician and responsible party. This failure had the potential for Resident 5 not to receive appropriate care and treatment.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised May 2017 showed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical / mental condition and or/status. The nurse will notify the resident's attending physician or physician on call when there has been accident or incident involving resident.specific instruction to notify the physician of changes in resident's condition. On 4/21/26 at 1026 hours, and 4/22/26 at 0925 hours, Resident 5 was observed lying in bed with dried eye discharge and redness at the corner of the right eye. In addition, Resident 5 was observed with a dark purplish discoloration on the right dorsal hand and a light purplish discoloration on the left posterior lower arm. Medical record review for Resident 5 was initiated on 4/21/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 2/19/26, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's Admission/readmission Screen and Baseline Care Plan 4.1 dated 2/19/26, showed Resident 5 had greenish skin discoloration in left and right dorsal hand. Review of Resident 5's Care Plan dated 2/19/26, showed Resident 5 was at high risk for bruising and bleeding related to anticoagulation. The interventions included reporting new areas of bruising to the physician and the responsible party/surrogate decision maker. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 had severely impaired cognitive skills for daily decision making and was dependent on the staff for his activities of daily living. Further review of Resident 5's medical record showed no documentation the physician or responsible party were notified about the right eye redness with discharge, the dark purplish discoloration on the right dorsal hand, or the light purplish discoloration on the left posterior lower arm. There was also no documentation in the resident's medical record showing these findings were monitored. On 4/23/26 at 1120 hours, an observation, interview and concurrent medical record review for Resident 5 was conducted with LVN 2. Resident 5 was observed in the therapy room. LVN 2 verified the resident's right eye redness and the purplish discolorations on both upper extremities. LVN 2 stated the resident had greenish discoloration on admission, but the purplish discolorations were new findings and should have been reported to the physician and responsible party. LVN 2 verified she was unable to find any documentation of notification or monitoring. On 4/23/26 at 1519 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated she had been caring for Resident 5 for the past three days. LVN 1 stated Resident 5 frequently had a small amount of eye discharge in the morning and difficulty opening his right eye, with some redness in the corner of the eye nearly every day she worked. LVN 1 stated she cleaned the eye, the resident appeared fine afterward. When asked whether this condition was normal, she stated it was normal for the resident; however, she acknowledged the eye appeared more red that day. On 4/23/26 at 1513 hours, an interview was conducted with the IP. When asked whether morning eye discharge with redness was normal for Resident 5, the IP stated eye discharge with redness is not normal in any resident and must be reported to the physician and responsible party immediately. On 4/24/26 at 0946 hours, an interview was conducted with CNA 2. CNA 2 stated on 4/16/26, she noticed Resident 5 had right eye redness with discharge and notified the assigned LVN. CNA 2 also reported on 4/23/26 around 0830 hours, she noticed the resident's eye was more red and she notified LVN 1 but did not document the (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification. CNA 2 stated she had not noticed the purplish discoloration on Resident 5's arms and could not determine whether it was new or present on admission. On 4/24/26 at 0952 hours, a follow up interview was conducted with LVN 1. LVN 1 verified she was notified by CNA 2 regarding Resident 5's eye discharge with redness on 4/23/26 at around 0830 hours. LVN 1 verified she did not notify the physician right way and only notified the physician after it was brought up during the investigation. LVN 1 stated the physician subsequently prescribed an antibiotic eye drop. On 4/24/26 at 1058 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. Cross reference F726

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	04/24/2026

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Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for one of three final sampled residents (Resident 9) reviewed for pressure injuries. * The facility failed to ensure Resident 9's LAL mattress was used correctly and was not covered by an additional foam mattress topper. This failure had the potential to contribute to the development of new pressure injuries or worsening of existing pressure injuries for Resident 9.Findings: Review of the facility document titled Adapt Pro Elite Model 9200 User Manual showed the Adapt Pro Elite (type of LAL mattress) is intended to help and reduce the incidence of pressure sores while optimizing patient's comfort. Medical record review for Resident 9 was initiated on 4/21/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 3/11/26, showed the resident had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician order:- dated 3/11/26, for Low Air Loss mattress for skin management every shift. On 4/21/26 at 1128 hours, an observation and concurrent interview was conducted with Resident 9 in his room. Resident 9 was observed lying on a LAL mattress with a foam mattress topper placed on top of it. Resident 9 stated the foam topper had been added approximately 10 days prior. Resident 9 stated his son had purchased it, and that the facility staff assisted him in placing it on top of the LAL mattress. On 4/21/26 at 1132 hours, an observation and concurrent interview was conducted with LVN 1 in Resident 9's room. LVN 1 verified the foam mattress topper was placed on top the LAL mattress. LVN 1 stated she had not noticed it earlier that day and was not aware it was in place. LVN 1 stated the foam topper should not be placed on top of the LAL mattress because it defeated the therapeutic purpose of the LAL mattress. On 4/21/26 at 1135 hours, an observation and concurrent interview was conducted with LVN 2 in Resident 9's room. LVN 2 stated she had provided treatment to Resident 9 the day before but did not notice the foam topper on top of the LAL mattress. LVN 2 stated Resident 9 had a pressure injury on the sacrococcyx. LVN 2 stated the LAL mattress would not function effectively if another mattress topper was placed on top of it. LVN 2 verified the foam topper was present and asked the resident's permission to remove it from the LAL mattress. On 4/24/26 at 1129 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. The DON stated the LAL mattress should not have an additional mattress topper placed on top of it.

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	056271	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure an appropriate pain management were provided for one of one final sampled resident (Resident 4) reviewed for pain management. * The facility failed to ensure the nonpharmacological interventions for pain management were provided before the administration of the pain medication for Resident 4. This failure had the potential to result in Resident 4 not receiving appropriate and comprehensive pain management.Findings: Review of the facility's P&P titled Pain Assessment and Management dated 3/2015 showed the purpose of the procedure was to help facility staff to identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address underlying causes of pain. Further review of the P&P showed nonpharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include:- Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.;- Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.;- Exercise - range of motion exercises to prevent muscle stiffness and contractures; and- Cognitive or Behavioral - relaxation, music, diversions, activities, etc. Medical record review for Resident 4 was initiated on 4/21/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 3/31/26, to administer celecoxib (medication used to relieve pain and inflammation) 200 mg one capsule by mouth one time a day for pain management. Review of Resident 4's MAR dated 4/1 through 4/30/26, showed a physician's order to administer celecoxib 200mg to one capsule by mouth one time a day for pain management. The MAR showed on 4/1/26 at 0730 hours, the above medication was administered, and the resident's pain level was documented as 2 (on a pain scale of 0 to 10, with 0 indicating no pain and 10 indicating the worst possible pain). However, further review of Resident 4's medical record did not show the nonpharmacological interventions were offered when Resident 4 had the pain level of 2 on 4/1/26 at 0730 hours. On 4/23/26 at 1457 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 verified Resident 4's pain level was documented as 2 on 4/1/26 at 0730 hours, at the time the celecoxib 200 mg was administered. RN 1 was unable to provide documentation showing what nonpharmacological interventions were offered or provided for Resident 4 prior to administering the pain medication. RN 1 stated nonpharmacological interventions should be provided when a resident reports pain prior to administering pain medication. On 4/24/26 at 1058 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged 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	04/24/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the nursing staff demonstrated competency in providing care and identifying changes in condition for Residents 5 and 87. * The facility failed to ensure LVN 1 was competent in identifying eye redness with discharge in Resident 5 and notifying the physician and responsible party. * The facility failed to ensure LVN 2 was adequately trained and competent in the use of the APP machine for Resident 87. These failures had the potential to result in Residents 5 and 87 not receiving care and treatment in a safe and competent manner.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised May 2017 showed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical / mental condition and or/status. The nurse will notify the resident's attending physician or physician on call when there has been accident or incident involving resident.specific instruction to notify the physician of changes in resident's condition. On 4/21/26 at 1026 hours, and on 4/22/26 at 0925 hours, Resident 5 was observed laying in bed. Resident 5 was observed with dried eye discharge with redness in the corner of his right eye. Medical record review for Resident 5 was initiated on 4/21/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 2/19/26, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's MDS assessment dated [DATE] , showed Resident 5 had severely impaired cognitive skills for daily decision making and was dependent on the staff for his activities of daily living. Further review of Resident 5's medical record did not show any documentation that the physician or the resident's responsible party were notified about the rightˆeye redness with discharge. On 4/23/26 at 1120 hours, an observation and concurrent interview and record review for Resident 5 was conducted with LVN 2. Resident 5 was observed in the therapy room. LVN 2 confirmed Resident 5 had redness all over in his right eye. LVN 2 verified she was not able to find documented evidence if Resident 5's right eye redness was reported to the physician and resident's responsible party, and if it was monitored. On 4/23/26 at 1519 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 1. LVN 1 stated she had been caring for Resident 5 for the past three days. LVN 1 reported that Resident 5 frequently had a small amount of eye discharge in the morning and difficulty opening his right eye, with some redness in the corner of the right eye almost every day. LVN 1 stated she cleaned the eye, and afterwards the resident could open it and appeared fine. When LVN 1 was asked if the morning eye discharge with redness was normal, she stated it was normal for Resident 5, so she did not notify the physician and resident's representative; however, the resident's eye appeared more red that day. (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/26 at 1513 hours, an interview was conducted with the IP. When asked if the eye discharge in the morning with redness observed in the resident was normal, the IP stated the eye discharge with redness was not normal in any residents and needed to be reported to the physician and the resident's responsible party right away. On 4/24/26 at 0946 hours, an interview was conducted with CNA 2. CNA 2 stated on 4/16/26, she noticed Resident 5 had right^eye redness with discharge and notified the assigned LVN. CNA 2 also reported that on 4/23/26, she noticed the resident's eye was more red and she notified LVN 1 around 0830 hours, but she did not document the notification. CNA 2 stated she did not notice the purplish discoloration on Resident 5's arms and was unsure whether it was new or present on admission. On 4/24/26 at 0952 hours, a follow up interview was conducted with LVN 1. LVN 1 verified she was notified by the CNA 2 regarding Resident 5's eye discharge with redness on 4/23/26 at around 0830 hours. LVN 1 verified she did not notify the physician right way, and notified the physician after it was brought up during the investigation. LVN 1 stated Resident 5 was then prescribed antibiotic eye drop for eye redness. On 4/24/26 at 1058 hours, an interview was conducted with the DON and the Administrator. The DON and the Administrator were informed and acknowledged the above findings. Cross reference to F684 2. Review of the facility's document titled Job Descriptions - Treatment Nurse (undated) showed the duties and responsibilities of the treatment nurse included providing preventive healthcare services, and assisting in monitoring the inventory of medications, medical supplies and equipment. The Job Description form did not include training and education on the use of pressure redistribution equipment such as APP machines. Review of the manufacturer's APP and Bubble Pad User Manual (undated) showed to use the pressure adjustable knob to give maximum resident comfort. On 4/21/26 at 0933, 1222, and 1557 hours, Resident 87 was observed lying in bed, with an APP machine attached to the foot board of the bed. The APP mattress setting was observed at 180. Medical record review for Resident 87 was initiated on 4/21/26. Resident 87 was readmitted to the facility on [DATE]. Review of Resident 87's Order Summary Report showed a physician's order dated 3/14/26, to provide APP mattress in bed for skin management. Review of Resident 87's Weight Summary Report showed Resident 87 weighed 101 lbs., for the week of 4/8 and 4/22/26. On 4/22/26 at 1424 hours, Resident 87 was observed lying in bed, with an APP machine attached to (continued on next page)

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	056271	A. Building B. Wing	04/24/2026

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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the foot board of the bed. The APP machine setting was observed at 280 (firmest level). On 4/22/26 at 1425 hours, an observation for Resident 87 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 87 was in bed, with the APP mattress setting at 280. CNA 1 stated she did not touch the APP machine dial. CNA 1 stated the CNAs reported to the treatment nurse if they had problems with the APP mattress. On 4/22/26 at 1439 hours, an observation for Resident 87 and concurrent interview and medical record review was conducted with LVN 2. LVN 2 stated she was the treatment nurse, and responsible for monitoring the APP machines. LVN 2 verified Resident 87 was in bed, with the APP mattress setting at 280. LVN 2 stated the APP mattress setting maybe adjusted based on the resident's comfort. When asked about the numerical settings on the APP machine, LVN 2 was unable to explain the meaning of the numerical settings on the control panel of the device, including how the numbers correlate with pressure settings or the resident's comfort. LVN 2 stated the facility had recently purchased the equipment and she was used to using the old APP machine which utilized a simplified simple to firm settings. When asked if she had received training or in-service education on the newly purchased APP machine, LVN 2 answered no. There was no documented evidence provided to ensure competency validation or training had been completed prior to use of the newly purchased APP device on residents. On 4/23/26 at 1340 hours, an interview was conducted with the DON and the Administrator. The DON and the Administrator were informed and acknowledged the above findings. Cross reference to F657, example #1.

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	056271	A. Building B. Wing	04/24/2026

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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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. Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services were provided to maintain proper medication storage for one of three medication carts (Medication Cart A) inspected. * The facility failed to ensure the orally administered medications were stored separately from the externally used medications. This failure had the potential to have negative impact the residents' well-being, and the potential for the medications to be contaminated, lose stability, and effectiveness.Findings: Review of the facility's P&P title Storage of Medications revised 4/2007 showed drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications. On 4/22/26 at 1400 hours, a medication cart inspection for Medication Cart A was conducted with LVN 3. The following was observed: - one box of alendronate sodium (medication use to treat or prevent thinning of the bone) 7 mg tablets and 11 individually packaged pantoprazole DR (medication use to treat acid reflux) 40 mg suspensions (oral/internal medication) were stored with 12 individual patches of rivastigmine transdermal system 4.5 mg (external medication) in a storage cube located in the first drawer of Medication Cart A. LVN 3 verified the above findings. LVN 3 stated the internal and external medications should not be stored in the same storage cube because the medications were administered by different routes and mixing them could cause medication errors or contamination. On 4/22/26 at 1415 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified that internal and external medications were stored together in the first drawer of Medication Cart A. RN 1 stated these medications must be stored separately to prevent contamination and potential medication errors On 4/24/26 at 1104 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged of the above findings.

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	056271	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interview, and facility P&P review, the facility failed to ensure safe food handling of food brought for the residents from outside sources. * The facility failed to ensure two staff (CNA 3 and LVN 5) were knowledgeable regarding the facility's P&P for food brought in by families or visitors. In addition, the facility failed to follow its P&P requiring outside food be stored in a designated unit to ensure safety. These failures posed the risk of the residents not being able to enjoy foods brought from outside in a safe and accessible manner.Findings: Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 10/25 showed food was to be stored in a way to facilitate safety. Facility could store the food in a designated unit, and it was recommended the food was consumed within three days of preparation. On 4/22/26 at 1550 hours, an observation and concurrent interview was conducted with the DSS. When asked about the refrigerator used to store food for the residents brought in from outside, the DSS showed the walk-in refrigerator with metal shelving. The refrigerator contained an open box of pasteurized eggs and other food items used by the kitchen for meal preparation. The DSS verified there was no dedicated space to store outside food from facility food items and acknowledged this could result in crossˆcontamination. On 4/23/26 at 1540 hours, an interview was conducted with CNA 3. When asked about food brought in from outside sources and where these foods were stored for the residents, CNA 3 stated she instructed the families and residents to take the food back home. On 4/23/26 at 1542 hours, an interview was conducted with LVN 5. When asked about food brought in from outside sources and where these foods were stored for the residents, LVN 5 stated the facility did store food brought in from the outside. LVN 5 stated the residents were required to eat the food immediately or it had to be discarded after two hours because the facility did not have a refrigerator designated for storing outside food. On 4/24/26 at 1100 hours, an interview was conducted with the Administrator, DON, and DSS. The Administrator, DON, and DSS were informed of 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	04/24/2026

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure coordination and consistency between the facility and hospice provider for one of one final sampled resident (Resident 13) reviewed on hospice services. * The facility failed to ensure the current frequencies of hospice staff visits as shown in the hospice plan of care were transcribed into Resident 13's physician's orders. In addition, the facility failed to ensure the hospice aide visit notes were maintained in the resident's medical record. These failures placed Resident 13 at risk for a breakdown in hospice care coordination and recordkeeping and could potentially result in delays in providing hospice care and services to Resident 13.Findings: Review of the facility's P&P titled Hospice Program revised 7/2017 showed the following:- In general, it is the responsibility of the facility to [NAME] the resident's personal care and nursing needs in coordination with the hospice representatives, and ensure that the level of care provided is appropriately based on the individual resident needs. These include: communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day; and- The facility designee to coordinate care provided to the resident by the facility staff and the hospice staff and is responsible for communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family, and for obtaining the information from the hospice such as hospice physician and attending physician orders specific to each resident. Review of the facility's document titled Hospice Nursing Home Patient Care Agreement with Hospice Provider A dated 6/26/25, showed the following:- Under Article 1.5, Services: Cheanges in Plan of Care: Hospice Provider A shall provide the facility with any changes in the plan of care and/or attending physician's, hospice medical director, or physician designee orders pursuant to the plan of care;- Under Article 1.6, Services: Coordination, Supervision and Evaluation of Services: Hospice Provider A shall appoint an RN as case manager who shall be responsible for the supervision and coordination of each resident's hospice care including hospice-related services to be provided by the facility as authorized and directed by the resident's attending physician, hospice medical director, or physician designee; and- Under Article 1.8, Services: Resident Record/ Documentation: Hospice Provider A shall make available to the facility the resident hospice records and other relevant resident information as necessary for the facility to provide services under this agreement. All such information and records shall be maintained in confidence by the facility. The facility shall maintain medical records of resident services for Hospice Provider A's hospice residents. Medical record review for Resident 13 was initiated on 4/21/26. Resident 13 was readmitted to the facility on [DATE]. a. Review of Resident 13's Order Summary Report showed the following physician's orders:- dated 7/18/25, to admit the resident to hospice services under Hospice Provider A; and- dated10/15/25, Hospice Provider A visits: RN care manager visits two times per week, and as needed, Social Worker visits two times per month and as needed, Spiritual Counselor visits once per month and as needed, and CHHA visits twice per week. b. Review of Resident 13's Hospice IDG Comprehensive Assessment and Plan of Care Update Report for benefit period dates from 2/4 to 4/4/26, showed the following:- Skilled nurse visits one time per week for two weeks, effective 3/22/26;- Skilled nurse visits one time per week for nine weeks, and four visits as needed for symptom management, effective 4/5/26;- Social worker visits two times per month for two months, and two visits as needed for psychosocial support, effective 3/1/26;- Social worker visits four times per month for two months, then one time per month, and two visits as needed for psychosocial support;- CHHA visits two times per week for nine weeks, and one time per week, effective 4/5/26; and- Chaplain visits two times per month for two months and three visits as needed for emotional and (continued on next page)

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	04/24/2026

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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spiritual support. c. Review of Resident 13's hospice binder and medical record did not show hospice aide visit notes for April 2026. Further review of Resident 13's medical record did not show any documented evidence the facility reconciled or clarified the physician's order and hospice plan of care to ensure consistency in the frequency of hospice staff visits. There was also no documented evidence verifying whether hospice aide visits occurred as scheduled. On 4/23/26 at 1028 hours, an interview and concurrent medical record review for Resident 13 was conducted with the SSD. The SSD verified she was the facility's hospice coordinator. The SSD stated she was responsible for coordinating with Hospice Provider A, making sure the hospice certification was up to date, and arranging the care plan meeting quarterly. When asked about reconciling and clarifying the frequency of hospice staff visits, and maintaining the hospice staff visit notes, the SSD stated the licensed nurses were responsible for checking the physician's orders, and the hospice staff visit notes. The SSD stated the licensed nurses would inform her if there were any issues with the visits and the notes, so she could follow up with Hospice Provider A. On 4/23/26 at 1051 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the frequency of the hospice staff visits as per the physician's order did not match the frequency of the hospice staff visits on the hospice plan of care. RN 2 verified there was no documentation to show the licensed nurses, or the SSD reconciled or clarified the physician's order and hospice plan of care regarding the frequency of the hospice staff visits. When asked about the hospice aide visit notes for April 2026, RN 2 could not provide documentation of the hospice aide visit notes for April 2026 or documentation to show the licensed nurses or the SSD followed up with Hospice Provider A regarding the missing hospice aide visit notes. On 4/23/26 at 1340 hours, an interview was conducted with the Administrator and DON for Resident 13. The Administrator and DON were informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, facility document review, and the facility P&P review, the facility failed to ensure the essential equipment was maintained in safe and operating condition for one of three glucometers (a device which measures the amount of sugar in the blood) inspected. * The facility failed to ensure the glucometer in Medication Cart A was calibrated and had quality control testing performed on 4/21/26. This failure had to result in inaccurate blood glucose readings for the residents of the facility requiring blood glucose monitoring.Findings: Review of the facility's P&P titled Quality Control Testing on Assure Glucometer dated 10/1/23, showed quality control testing using the Assure Dose Control Solution will be performed to examine the performance of the Assure Blood Glucose Monitoring System. The Assure Dose Control Solution checks if the meter and test strips are working correctly as a system and if you are testing correctly. A control solution test should be performed every night. Review of the facility document titled Quality Control Record dated 4/2026 for Medication Cart A showed no documented evidence the glucometer with serial number 1040-4515600 was calibrated, or if quality control testing was performed on 4/21/26. The log was blank for 4/21/26. On 4/22/26 at 1440 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 3. LVN 3 verified the above findings and stated the licensed nurses on the 11-7 shift (2300 to 0700 hours) calibrated the glucometer and performed the quality control testing. LVN 3 further stated the glucometers and quality control testing were checked nightly to ensure accurate blood glucose readings for the residents. On 4/24/26 at 1132 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure for a safe and comfortable environment for the staff, vendors, and visitors as evidenced by: * The facility failed to ensure hot water temperatures at one kitchen handwash sink and the two compartment manual dishwashing sink were maintained at a safe and comfortable temperature level. This failure posed the risk of burn injuries to the staff, vendors, and visitors.Findings: Review of the State Operations Manual, Appendix PP Table 1, titled Time and Temperature Relationship to Serious Burns showed for a water temperature of 148 degrees Fahrenheit, the time required for a third degree burn to occur was two seconds. Further review of this table showed that for a water temperature of 150 degrees Fahrenheit, the time required for a third degree burn to occur was one second. On 04/21/26 at 1038 hours, the hot water from the kitchen handwash sink located near the DSS's office felt abnormally hot to the touch. Dietary Aide 1 verbalized the water was often very hot. The sinks inside the kitchen were observed with Caution - Hot Water signage. On 4/22/26 at 1210 hours, an interview was conducted with the DSS. The DSS confirmed the Caution - Hot Water signs were posted to warn individuals that the sink water was hot. When asked whether the facility maintained a temperature log to monitor hot water temperatures at the kitchen sinks, the DSS stated they did not. On 4/23/26 at 0852 hours, an observation and concurrent interview was conducted with the DSS. The hot water coming out from the kitchen handwash sink located near the DSS's office felt abnormally hot to the touch and steam was visibly rising from the water. When asked to check the temperature of the hot water, the DSS measured the temperatures of both the kitchen handwash sink and the two compartment manual dishwashing sink. Both measured 151.9 degrees Fahrenheit. The DSS verified the above findings.