STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056401	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Hills Post Acute Care	3680 Reynard Way San Diego, CA 92103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review, the facility failed to ensure a baseline care plan (the minimum healthcare information necessary to properly care for each resident immediately upon their admission) meeting was conducted within 48 hours for two residents (Resident 2 and 6) reviewed for baseline care planning. This failure had the potential for an incomplete and lack of care interventions for residents in an event of a serious change of condition to potentially occur to residents after admission. In addition, the lack of communication among facility staff and responsible party had the potential to affect the quality of care to the resident. Findings: 1. Resident 2 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy (a disease of the heart muscle causing the heart to have a harder time pumping blood to the rest of the body) and prostate (part of the reproductive system in men) cancer according to the facility's Admission Record. During an interview on 1/10/24 at 1:39 pm with Resident 2's family member, the family member stated Resident 6 was transferred to the hospital. The family member stated there was no meeting about Resident 2's care and a physician did not visit Resident 2 until the family complained to the Director of Nursing. A review of Resident 2's medical records was conducted. A document titled, IDT-Care Plan Review, dated 1/7/25 was reviewed. The document indicated, IDT Conference Conducted Secondary to: Initial Review . Resident 2 was admitted to the facility on [DATE] and the IDT conference was not conducted until 1/7/25, which was 28 days after Resident 2's admission to the facility. The document did not have Resident 2 or family's signature indicating they have not received any information. 2. Resident 6 was admitted to the facility on [DATE] with diagnoses including injury of muscle, fascia (a sheath of tissue surrounding every part of the body) and tendon of lower back and Alzheimer's Disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) according to the facility's Admission Record. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a complaint investigation on 1/10/25, Resident 6's family member stated a list of staff contact list was not provided to the family until 12/10/24, which was 13 days after admission. The family member stated Resident 6's family was not instructed on how to set up a care plan meeting until 12/4/24 in which the family was only given only one date for the following week, for the meeting to take place. A review of Resident 6's records were conducted. A document titled, IDT-Care Plan Review, dated 12/10/24 was reviewed. The document indicated, IDT Conference Conducted Secondary to: Initial Review . Resident 6 was admitted to the facility on [DATE] and the IDT conference was conducted on 12/10/24 which was 13 days after Resident 6's admission to the facility. The document did not have Resident 2 or family's signature, indicating they have not received any information. An interview on 1/27/24 at 1:19 P.M. with the Director of Social Services (DSS) was conducted. The DSS stated residents were offered an initial care plan meeting within 7 days of admission. The DSS stated the initial care plan meeting was the baseline meeting for the resident. The DSS stated there was no other care plan meeting for the resident until the following quarter if the resident was still at the facility. The DSS further stated the resident and or the resident's responsibly party were only given a copy of the care plan meeting upon request. An interview was conducted with the Director of Nursing (DON) on 1/28/24 at 2:56 P.M. The DON stated it was important to conduct the baseline care plan meeting because it provided the resident and/or the family member communication regarding the resident's care and what to expect while the resident was in the facility. A review of the facility's undated policy and procedure titled, Care Planning was conducted. The P&P indicated, .Scheduling and preparation of the care plan meeting calendar is completed by the Social Services Director/Assistant .The Social Services Director/or Social Services staff will notify the resident, family and/or responsible party .of the date and time of the care plan conference . The policy and procedure did not provide guidance regarding completion of a baseline care plan and the acceptable guidelines for completing a comprehensive care plan.