STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555487	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission DE LA Casa	2501 Alvin Avenue San Jose, CA 95121

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 31524 Based on interview, record review, and facility document and policy review, the facility failed to ensure Level I Preadmission Screening and Resident Reviews (PASARRs) were accurate for 2 (Resident #67 and Resident #138) of 2 residents reviewed for PASARR requirements. Specifically, the facility failed to ensure the resident's PASARRs accurately reflected their mental health diagnoses. Findings included: The facility policy titled, Preadmission Screening and Resident Review, revised in 03/2023, indicated, The facility ensures individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting when a significant change in their status occurs. 1. An Admission Record revealed the facility admitted Resident #138 on 05/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of adjustment disorder with depressed mood with an onset date of 01/25/2024 and brief psychotic disorder with an onset date of 02/08/2024. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #138 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. The MDS also indicated Resident #138 had an active diagnosis of psychotic disorder and received an anti-depressant medication during the seven-day look-back period. Resident #138's care plan included a focus area, initiated on 05/02/2024, that indicated the resident had a mood problem manifested by poor appetite related to a diagnosis of depression. Another focus area, initiated on 05/02/2024, indicated the resident had a diagnosis of brief psychotic disorder. Resident #138's Level I PASARR, dated 05/01/2024, indicated the resident did not have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance. The Level I PASARR did not reflect the resident's diagnoses of depression or psychotic disorder, and the screening results were Negative, due to No Serious Mental Illness. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 12:20 PM, Registered Nurse (RN) #3 stated she was responsible for ensuring the Level I PASARR was completed for new admissions. RN #3 stated the hospital initiated the PASARR, and she checked them for accuracy. RN #3 stated Resident #138's diagnoses should be reflected on their PASARR and confirmed the resident's Level I PASARR was inaccurate. During an interview on 06/26/2024 at 2:20 PM, the Director of Nursing (DON) stated Resident #138's Level I PASARR was inaccurate because it did not include the resident's psychosis or mood disorder diagnoses. The DON stated she expected Level I PASARRs to accurately reflect each resident's diagnoses and conditions to ensure residents are properly placed. During an interview on 06/26/2024 at 2:22 PM, the Quality Assurance (QA) Nurse stated if a resident was admitted from the hospital, the hospital completed the Level I PASARR, and the nurse supervisor was responsible for ensuring the PASARR was accurately completed. The QA Nurse further stated it was important to ensure the Level I PASARR was accurate upon admission so the facility could provide necessary care to the resident and make referrals to mental health providers, if needed. During an interview on 06/27/2024 at 9:08 AM, the Administrator stated he expected Level I PASARRs to accurately reflect residents' diagnoses. 37683 2. An Admission Record revealed the facility admitted Resident #67 on 03/31/2023. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder (11/04/2018) and post-traumatic stress disorder (PTSD) (onset date 11/05/2018). Resident #67's Level I PASARR, dated 03/31/2023, revealed the resident was diagnosed with major depressive disorder; however, the resident's diagnosis of PTSD was not reflected. The Level I PASARR was Positive, due to a suspected MI [mental illness]. A letter from the Department of Health Care Services to the facility, dated 04/12/2023, indicated the Level II evaluation was not completed because the resident had no serious mental illness (SMI). The letter indicated the case was closed. During an interview on 06/26/2024 at 12:20 PM, Registered Nurse (RN) #3 stated she was responsible for ensuring the Level I PASARR was completed for new admissions. RN #3 stated the hospital initiated the PASARR, and she checked them for accuracy. RN #3 stated Resident #67's diagnosis of PTSD should be reflected on their PASARR and confirmed the resident's Level I PASARR was inaccurate. During an interview on 06/26/2024 at 2:20 PM, the Director of Nursing (DON) stated she expected Level I PASARRs to accurately reflect each resident's diagnoses and conditions to ensure residents are properly placed. During an interview on 06/26/2024 at 2:22 PM, the Quality Assurance (QA) Nurse stated if a resident was admitted from the hospital, the hospital completed the Level I PASARR, and the nurse supervisor was responsible for ensuring the PASARR was accurately completed. The QA Nurse further stated it was important to ensure the Level I PASARR was accurate upon admission so the facility could provide necessary care to the resident and make referrals to mental health providers, if needed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/2024 at 9:08 AM, the Administrator stated he expected Level I PASARRs to accurately reflect residents' diagnoses.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36105 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the medication error rate was five percent (%) or less. Medication administration observations revealed 2 medication errors out of 25 total opportunities, resulting in a medication error rate of 8%, affecting 2 (Resident #137 and Resident #105) out of 5 residents observed during medication administration. Findings included: A facility policy titled, Administering Medications, revised in March 2023, revealed, 3. Medications must be administered in accordance with the orders. The policy further revealed, 8. The licensed nurse must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. An Admission Record revealed the facility admitted Resident #137 on 01/02/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of depression. Resident #137's Order Summary Report, listing active orders as of 06/25/2024, contained an order, dated 01/23/2024, for sertraline 50 milligram (mg) tablet, give two tablets by mouth one time daily for depression. The order also specified, Total Dose=100 mg. Observation of medication administration on 06/25/2024 at 8:28 AM revealed Licensed Vocational Nurse (LVN) #1 administered only one sertraline 50 mg tablet to Resident #137, instead of two tablets to equal 100 mg as ordered by the physician. An Admission Record revealed the facility admitted Resident #105 on 07/09/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified dementia. Resident #105's Order Summary Report, listing active orders as of 06/25/2024, contained an order, dated 03/04/2024, for memantine 5 mg tablet, two tablets by mouth one time daily for dementia. Observation of medication administration on 06/25/2024 at 8:49 AM revealed LVN #1 administered only one memantine 5 mg tablet to Resident #105, instead of two tablets as ordered by the physician. During an interview on 06/25/2024 at 9:08 AM, LVN #1 stated she missed giving Resident #137 their second sertraline tablet and missed giving Resident #105 their second memantine tablet. LVN #1 stated she should have read the entire order before giving the medications. During an interview on 06/25/2024 at 9:14 AM, Registered Nurse (RN) #2 stated LVN #1 had underdosed Resident #105 and Resident #137 by giving only half the ordered dose of their medications. RN #2 stated the nurse should have read the entire order before administering the medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2024 at 1:07 PM, the Director of Nursing (DON) stated the nurse should have matched the medication card to the order screen, should have read the entire order, and should have given all medications as ordered. During an interview on 06/27/2024 at 8:43 AM, the Administrator stated he expected the ordered dosage of medication to be administered to the residents. The Administrator said staff should follow the physician's orders when administering medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37683 Based on observation, interview, and facility policy review, the facility failed to sanitize the food thermometer between measuring the temperatures of different food items. This had the potential to affect 138 of 138 residents who received food from the dietary department. Findings included: A facility policy titled, Safe Food Preparation, revised in March 2023, revealed, Cross-Contamination 2. Cross-contamination can occur when harmful substances, i.e. [id est, such as] chemical or disease-causing microorganisms are transferred to food by hands, (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. 3. Examples of ways to reduce cross-contamination include, but are not limited to: d. Clean and sanitize work surfaces, including cutting-boards and food-contact equipment (e.g. [exempli gratia, for example] food processors, blenders, preparation tables, knife blades, can openers, and slicers), between uses and consistent with applicable code. A facility policy titled, Food Temperatures, revised on 03/19/2020, revealed, 1. Wash, rinse and sanitize a dial face, metal probe-type thermometer with alcohol wipe. The policy specified, Re-sanitize the thermometer after each use. An observation of the measurement of food holding-temperatures on 06/26/2024 at 11:07 AM revealed [NAME] #4 did not sanitize the thermometer between measuring the holding-temperature of the pureed meat and the pureed egg roll. At 11:11 AM, [NAME] #4 did not sanitize the thermometer between measuring the holding-temperatures of pho broth, vegetables, salmon, rice, extra portions of pureed egg roll, mashed potatoes, beef, pureed vegetables, or vegetable broth. During an interview on 06/26/2024 at 1:09 PM, [NAME] #4 stated he was trained to sanitize the thermometer between food items. During an interview on 06/26/2024 at 11:13 AM, the Dietary Supervisor stated staff should sanitize the thermometer between food items using a sanitizing wipe. During a follow-up interview on 06/26/2024 at 1:26 PM, the Dietary Supervisor stated it was important to sanitize the thermometer between food items to avoid cross-contamination. During an interview on 06/27/2024 at 8:50 AM, the Director of Nursing (DON) stated she expected staff to sanitize the food thermometer between food items to avoid cross-contamination. During an interview on 06/27/2024 at 9:09 AM, the Administrator stated he expected staff to follow the facility policy and to sanitize the food thermometer between different food items.