STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555796	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care Center	4800 Delta Avenue Rosemead, CA 91770

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36925 Based on interview and record review, the facility failed to ensure that a wheelchair sensor pad alarm (a weight-sensitive sensor pad that is connected to a monitor unit and activates an alarm if a patient leaves the chair or the bed) was placed on the wheelchair (a mobility device that helps a person with mobility impairment to move around) of one of three sampled residents (Resident 1). This deficient practice had the potential to result in multiple falls with injuries for Resident 1 who was assessed as high riskfor falls. Findings: During areview of Resident 1 ' s Admission Record, the Admission Record indicated that the facility admitted the resident on 07/01/2019 and readmitted the resident on 09/19/2024 with diagnoses that included difficulty in walking, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a condition that causes weakness or an inability to move on one side of the body). During areview of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 09/25/2024, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and that the resident was dependent (helper does all the effort) on a person to transfer from a chair to the bed and vice versa. During a review of Resident 1 ' s Fall Risk Evaluation dated 09/19/2024 indicated that the resident was assessed as a High Risk for fall. During a review of Resident 1 ' s Physician Order dated 09/19/2024 indicated that the physician ordered to use a sensor pad in bed and in a wheelchair to remind the resident not to get up unassisted. During areview of Resident 1 ' s care plan, dated 09/19/2024, indicated that the resident was at risk for falls and one of the interventions indicated on the care plan was to include the use of a sensor pad when the resident was in the wheelchair for safety precaution. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During areview of Resident 1 ' s Progress Notes dated 11/01/2024 at 04:50 PM indicated that the resident was found lying on the floor in the dining room on his left side by a Certified Nurse Assistant (CNA) and was assisted back to his wheelchair. During a telephone interview with Family 1 (FAM 1) on 11/22/24 at 1:45 PM, FAM 1 stated that Resident 1 had an unwitnessed fall in the facility on 11/01/2024 while in his wheelchair. FAM1 stated that on four (4) separate occasions, she found Resident 1 ' s wheelchair sensor pad unplugged to the alarm. FAM 1 also stated that when she visited Resident 1 on 11/15/2024, the wheelchair sensor pad was missing from Resident 1 ' s wheelchair. During an interview with the Director of Staff Development (DSD) on 11/25/2024 at 12:12 PM, the DSD stated that FAM 1 asked DSD on 11/15/2024 why Resident 1 did not have the wheelchair sensor alarm applied to Resident 1 ' s wheelchair and confirmed that Resident 1 did not have the wheelchair sensor alarm applied to the wheelchair, while Resident 1 was seated in the wheelchair in the dining room. During an interview with the Director of Nursing (DON) on 11/25/24 at 3 PM, she stated that the facility conducted a fall risk evaluation on residents during admission, quarterly, annually, and during a change of condition. She stated that if a resident was assessed as a high risk for fall, the facility created a care plan with interventions that included a wheelchair sensor pad alarm to aid in the prevention of falls. The DON stated that if the facility did not carry out the interventions according to the plan of care, the resident could be exposed to accidents, such as a fall, that could result to serious injuries. During a review of the facility ' s undated policy titled; Fall Management System revised in 03/2024 indicated that the facility is committed to promoting resident autonomy by providing an environment that remains free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision and assistive devices to prevent accidents.