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	12/10/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) who has pressure injuries (damaged skin and tissue from too much pressure) on the left ischium (bottom-rear section of pelvic bone) and right heel had a low air loss mattress (LAL - designed to prevent and treat pressure injury) set at the setting according to residents weight as indicated in the manufacturer's guidelines to prevent and/or minimize skin pressure on the bony prominences of the body. This deficient practice had the potential to result in delay healing of Resident 1's pressure injuries and may result in new pressure injuries that may negatively affect Resident 1's quality of life.Findings: During a review of Resident 1's admission Record (AR), dated 12/10/2025, indicated Resident 1 was admitted [DATE], with diagnoses that included surgery on the genitourinary system (body parts responsible for both making and eliminating urine), retention of urine (a condition in which you are unable to empty all the urine from your bladder), history of physical injury and paraplegia (loss of movement and sensation, in the lower half of the body, including the legs). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 11/2/2025, indicated Resident 1's cognitive status (ability to process and comprehend information) was intact. The MDS indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with personal hygiene and dependent (helper does all the effort) with toileting, bathing, and dressing. The MDS indicated Resident 1 had pressure injury on the left ischium and right heel. During a review of Resident 1's Braden Scale for Predicting Pressure Sore (skin injury) Risk dated 11/2/2025 indicated Resident 1 was moderate risk. During a review of Resident 1's Order Summary Report (OSR) dated 12/10/2025, the OSR indicated Resident 1 was placed on: a) Low Air Loss Mattress for tissue management b) treatment for pressure injury on left ischium, and c) treatment for right heel pressure injury. During a review of Resident 1's current weight, dated 12/4/2025 indicated, Resident weight was 197 pounds. During a concurrent observation and interview on 12/10/2025 at 12:30 PM with Treatment Nurse (TN) 1 in Resident 1's room, Resident 1 in bed on a LAL mattress pressures setting was set for 300 pounds person. TN 1 stated, Resident 1's weight this month was 197 pounds, the LAL mattress should be set according to Residents 1 weight, not at 300 pounds. TN 1 stated, she was responsible to make sure that the LAL mattress settings was according to Resident weight, she just forgot it this morning. TN 1 stated, LAL mattress not in the right setting had the potential to cause delay in Resident 1's healing of her pressure injuries and may result in new pressure injury. During an interview on 12/10/2025 at 2:50 PM with Director of Nurses (DON), DON stated, Resident 1 uses LAL mattress because of her pressure injuries and potential for risk for new pressure injuries, it is used to prevent and/or minimize skin pressure on the bony prominences of the body. Resident 1 LAL mattress pressure setting should be set according to the Resident 1's weight. DON stated, Resident 1's current weight was 197 pounds, so the LAL mattress should not be set at 300 pounds. DON stated, LAL mattress not at the right setting, potentially could result in delay healing of Resident 1's pressure injuries and may result in new pressure injuries. A review of the facility's policy and procedure (P&P) titled, Low Air Loss, Alternating Pressure Pad or Mattress, dated 01/2025, indicated, Low Air Loss mattress will be set up according to manufacturer's recommendations. A review of manufactures guidelines for the LAL mattress (Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System), (undated), indicated, the pressure of the mattress can be adjusted by choosing by choosing the patients corresponding weight setting. A review of the facility's policy and procedure (P&P) titled, Skin Management, revised 10/2025, indicated, to prevent the development of skin breakdown or prevent pressure injuries from worsening nursing staff shall implement approaches such as reportioned the resident and use of pressure relieving /reducing device (including but not limited to low air loss mattress).

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's infection control protocols by ensuring Certified Nursing Assistant (CNA) 1 and Treatment Nurse (TN) 1 wore an isolation gown when providing direct contact care for one of one sampled residents (Resident 1) who was placed on Enhanced Barrier Precautions (EBP-an infection prevention and control intervention to reduce the spread multidrug resistant organisms [MDRO- disease causing organism resistant to medication used to treat infection]) due to the resident having a supra pubic stoma for intermittent catheterization (a small tube placed directly into the bladder through a tiny opening above the pubic bone, to drain urine) and a right heel and left ischium (back part of the hip bone) pressure injury (localized skin and tissue damage from constant pressure). This deficient practice had the potential to result in Resident 1 acquiring MDROs, contaminating other areas and/or spreading MDROs to other residents in the facility which could negatively affect their health and quality of life.Findings: During a review of Resident 1's admission Record (AR), dated 12/10/2025, indicated Resident 1 was admitted [DATE], with diagnoses that included surgery on the genitourinary system (body parts responsible for both making and eliminating urine), retention of urine (a condition in which you are unable to empty all the urine from your bladder), history of physical injury and paraplegia (loss of movement and sensation, in the lower half of the body, including the legs). During a review of Resident 1's Minimum Data Set (MDS) -a resident assessment tool dated 11/2/2025, indicated Resident 1's cognitive status (ability to process and comprehend information) was intact. The MDS indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with personal hygiene and dependent (helper does all the effort) with toileting, bathing, and dressing. The MDS indicated Resident 1 had pressure injury on the left ischium and right heel. During a review of Resident 1's Order Summary Report (OSR) dated 12/10/2025, the OSR indicated Resident 1 was placed on: a) on Enhanced Barrier Precautions due to suprapubic intermittent catheterization and wounds, b) treatment for pressure injury on left ischium, and c) treatment for right heel pressure injury. During an observation on 12/10/2025 at 11 AM by Resident 1's doorway had a signage EBP indicating staff must wear gloves and isolation gown during high and direct contact resident care and activities. During an observation on 12/10/2025 at 11:30 AM in Resident 1's room (Resident 1 agreed to be observed) during a pressure injury treatment. Resident 1 was in bed touched and repositioned by both Certified Nurse Assistant (CNA) 1 and Treatment Nurse (TN) 1 for wound treatment, both CNA 1 and TN 1 were not wearing an isolation gown. During a concurrent interview on 12/10/2025 at 11:50 AM with CNA 1 and TN 1 (after Resident 1's wound care). CNA 1 stated, for Resident 1 wound treatment, she gave her bed bath, change brief and assisted TN 1 for positioning not wearing a gown. CNA 1 stated, she should have worn a gown to prevent the spread of infection, she forgot. TN 1 stated, she forgot to wear a gown during Resident 1's wound treatment. TN 1 stated wound treatment is considered high contact care, and Resident 1 was on EBP, so she should've worn a gown during care. TN 1 stated, not wearing a gown during high contact care had the potential to result in Resident 1 acquiring MDRO and potentially spread MDRO to other residents in the facility. During an interview on 12/10/2025 at 2: 38 PM with the Director of Nurses (DON), DON stated, Resident 1 was placed on EBP because she has supra pubic stoma for intermittent catheterization and pressure injury, staff should wear a gown during high contact care as per policy. DON stated, bed bath, changing brief are considered high contact care, CNA 1 should have worn a gown. DON stated, wound care is considered high contact care, TN 1 should have worn a gown. DON stated, not following policy of wearing a gown during high contact care with Resident 1 had the potential to result in in Resident 1 acquiring MDROs and/or spreading MDROs to other residents in the facility which could negatively affect their health and quality of life. A review of the facility's policy and procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, dated 6/2021, the P&P indicated, a) I the policy of the facility is to implement infection control measures to prevent the spread of communicable diseases and conditions, b) EBP- the use of isolation gown and gloves during high contact with the resident care and activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident to resident (Residents with wounds and indwelling medical devices are high risk for both acquisition of and colonization with MDROs), and c) examples of high-contact care activities requiring gown and glove use for EPB: bathing, changing briefs and wound care