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	03/19/2026

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

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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 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, and record review, the facility failed to ensure proper food safety and sanitation practices to prevent foodborne illness (also known as food poisoning caused by consuming contaminated food or water containing bacteria, toxins, viruses leading to symptoms like nausea, vomiting, diarrhea and stomach cramps) to the residents in accordance with the facility's policy and procedure titled Labeling and Dating of Foods. by failing to: 1.Perform hand hygiene after certified nurse assistant (CNA) 1 was observed touching a clean meal tray without washing or sanitizing hands after touching a dirty, soiled meal tray. 2.Perform hand hygiene after [NAME] 1 was observed using a rag to clean the soiled kitchen table surface prior to opening the refrigerator to obtain a bell pepper. 3. Ensure food items stored in a refrigerator and freezer were properly labeled with a use- by date (last date recommended for the use of the product while at peak quality). This deficient practice had the potential to result in contamination of food and food contact surfaces, increasing the risk of foodborne illness to residents. Findings: 1.During a concurrent observation and interview on 3/16/2026 at 8:42 AM with Dietary Supervisor 1, the following were observed: a. Pepperoni that was removed from the original package did not have an open or use by date. b. Two sour cream container was labeled with an open date of 2/25/2026 indicated a use by date of 3/15/2026 or 7 days. c. Dry cereal stored in individual bowls did not indicate an open or use by date. d. Hungarian – style paprika indicated a use by date of 2/1/2026, In a concurrent interview the DS confirmed expired food items should be discarded and stated all food items should be labeled with an open date and follow the storage guidelines. During an interview on 3/6/2026 at 9 AM with the Administrator (ADM), ADM stated food items (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed from their original packaging should be labeled with an open date and a use by date. ADM further stated that proper labeling was necessary to ensure food was not spoiled and remained safe for consumption. The ADM stated failure to label food appropriately could cause a health risk to residents. During another observation on 3/16/2025 at 8:37 a.m. in the kitchen, Refrigerator 3 had two expired sour cream containers with the expiration dates of 2/8/2026 and 3/15/2026. During a concurrent observation and interview on 3/17/2026 at 12:05 p.m. with Dietaryˆ Supervisorˆ (DS)) 1, DS1 stated consumption of expired dairy products could lead to food poisoning. Cooks are the ones required to discard the expired food items, at the end of each working day. 2.During an observation on 03/16/2026 at 12:22 PM in the dining room, certified nursing assistant (CNA) 1 was observed placing a dirty tray down onto the tray cart and then immediately touching a clean tray without performing hand hygiene or changing gloves. During an interview on 3/16/2026 at 12:28 PM with CNA 1, CNA 1 stated after touching a dirty tray, CNA 1 should have used hand sanitizer after placing the dirty tray down and prior to handling another residents' clean meal tray. During an interview on 3/16/2026 at 12:30 PM with RN 1, RN 1 stated that hand sanitizer should be used between handling a dirty tray and a clean tray. RN 1 stated by not performing hand hygiene in between touching a dirty meal tray and clean meal tray was an infection control issue and had the potential for cross contamination. 3.During a concurrent kitchen observation and interview on 3/17/2026 at 11:49 AM with [NAME] 1, [NAME] 1 was observed using a wet rag obtained from a bucket filled with chemical sanitizer to clean dirty kitchen surfaces, and the proceeded to open the refrigerator and removed bell peppers and placed the bell peppers on the kitchen table. [NAME] 1 did not perform hand hygiene or glove change prior to opening the refrigerator or after using the wet rag. [NAME] 1 stated hand hygiene should have been performed prior to food handling. During an interview on 3/17/2026 at 11: 55 AM with Certified Dietary Manager (CDM), CDM stated not performing hand hygiene after touching dirty services or prior to handling any food item could cause cross contamination and possible illnesses. During a record review of Refrigerated Storage guidelines dated 2023, the guidelines indicated cream, yogurt, cottage cheese, cream cheese, soft cheese, or sour cream had an expiration date of 7 days after opening, or to follow the expiration date, whichever came first. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedures (P&P) titled Food Handling, dated 2023, the P&P indicated food will be prepared and served in a safe and sanitary manner. All food & nutrition Services personnel will wash their hands prior to handling all food. Food & Nutrition Services personnel should never use bare hand contact with any foods, ready to eat or otherwise. This includes produce washing and food item preparation. Gloves should be changed before handling washed food items, as referenced in the glove use policy. During a review of facility's policy and procedures (P&P) titled Hand Washing Procedure, dated 2023, the P&P indicated Hand washing is important to prevent the spread of infection hands need to be washed after handling soiled dishes and utensils. During a review of facility's policy and procedure (P&P) titled Labeling and Dating of Foods) dated 2023, indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. The food delivered to facility needs to be marked with a delivery or received date. Some cultured dairy products such as milk, cream, yogurt, and sour cream are exempt from food code open date labeling requirements. This food shall be discarded by seven days after opening them. For other food that is commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked with a Use By date. The Use by date will incorporate the open date for TCS foods as defined by the Federal Food Code. The Use by date signified the date in which food must be consumed or discarded.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interviews, and record reviews, the facility failed to maintain trash in covered, properly contained, and sanitary receptacles. Three out of 3 large trash bins were observed overflowing with waste on the ground. This failure created the potential for vermin infestation and infection riskFindings: During an observation on 3/16/2026 at 2:21 pm, in the facility's trash bin area, three large trash bins were overflowing with multiple paper cups and paper towels were on the ground next to the trash bins. During an interview on 3/16/2026 at 2:30 pm, with the Dietary Supervisor (DS), the DS stated the trash bins need to be covered and secured at all times. DS stated that overflowing trash bins can develop pests and rodents in the facility. During an interview on 03/19/2026 at 9:39 am, with Director of Nursing (DON), the DON stated that if trash bins are not closed adequately and there is trash on the ground, it can attract vermin (small animals and/or insects like fleas, rats and cockroaches) in the facility which can spread infection. During a review of the facility's policy and procedure (P&P) titled, Garbage and Trash, dated 2023, the P&P indicated all food waste must be placed in sealed leak-proof, non - absorbent, tightly closed containers. The trash must be adequate, clean, vermin - proof areas must be provided for storage of garbage and rubbish.

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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 and record review the facility failed to implement the facility's policy and procedure for infection control by failing to: 1.Label the nasal cannula tubing (small, flexible plastic tube inserted into the body to deliver oxygen) for two of three sampled residents (Resident 52 and 27). 2. Ensure License Vocational (LVN) 2, performed hand hygiene (the act of cleaning your hands to remove germs, dirt, and viruses) when entering and exiting a room with Enhance Barrier Precautions (EBP- a protocol requiring staff to perform hand hygiene, using gowns and gloves when entering a resident's room who has a wound vac [medical device that uses suction to accelerate healing in skin wounds]). 3. Ensure the Enhance Barrier Precautions sign was posted outside the room for one of three sampled residents (Resident 52). 4. Ensure LVN 2 performed hand hygiene after administering Resident 10's suppository (a type of medication that is administered through the rectum) and before administering Resident 10s' oral medication. This deficient practice placed the residents at risk of developing infections Findings: 1.During review of Resident 52's medical record, resident was originally admitted on [DATE], diagnosed with acute respiratory failure with hypoxia (when body's tissues and organs do not receive enough oxygen to function properly) and pleural effusion (water on the lungs). During review of Resident 52s's physician orders dated 3/16/2026, the order indicated residents' oxygen tubing be changed every week. During review of Resident 27's medical record, resident was originally admitted on [DATE], diagnosed with chronic obstructive pulmonary disease (lung disease that makes it hard to breathe), immunodeficient (body's immune system is weak) and obstructive sleep apnea (sleep disorder where your breathing repeatedly stops). During review of Resident 27's physician orders dated 2/16/2026, the order indicated residents' oxygen tubing be changed every week. During an observation on 3/16/2026 at 8:50 a.m. in Resident 52's room, Resident 52's nasal cannula tubbing was not dated. During an observation on 3/16/2026 at 8:53 a.m. in Resident 27's room, Resident 27's nasal cannula tubbing was not dated. During an interview on 3/18/2026 at 9:50 a.m. with License Vocational Nurse (LVN) 4, LVN 4 stated, nasal cannula therapy tubing is to be changed and labeled weekly. Not doing so could lead to resident inhaling bacteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/2026 at 10:08 a.m. with the Director of Staff Development (DSD), DSD sated cannula tubbing is replaced and labeled once a week by the assigned RNs or LVNs. This practice helps staff track how long the nasal tubing has been in use. DSD explained that failure to change the tubing as required could affect the amount of oxygen delivered to the resident. During a concurrent interview and record review on 3/18/2026 at 10:14 a.m. with Infection Preventionist (IP), the facility's policy and procedure (P&P) title, Oxygen Therapy, dated 12/2025 was reviewed. The P&P indicated, nasal cannula tubing is to be replaced every 7 days or as needed when dirty or soiled. Oxygen tubing to be dated when changed. IP stated not changing the oxygen tubbing could cause an infection and bacteria to collect and be passed on to the resident. 2 During a review of Resident 52's physician orders, dated 3/16/2026, the physician orders indicted EBP was needed due to wound vac therapy being used. During a concurrent observation and interview on 3/17/2026 at 12:05 p.m. outside Resident 52's room, LVN 2 did not perform hand hygiene when entering and exiting Resident 52's room who was on EBP. LVN 2 stated he did not perform patient care, therefor did not need to perform hand hygiene when entering and exiting a room. During a concurrent interview and record review on 3/18/2026 at 12:50 p.m. with Infection Preventionist (IP), the EBP sign dated 9/9/2024 was reviewed. The EBP sign indicated everyone must clean their hands on room entry and when exiting a room with EBP in place. If the staff does not perform hand hygiene when entering and exiting a room, it could cause the spread of infections and bacteria amongst all the residents. 3.During an observation on 3/16/2026 at 8:49 a.m., inside Resident 52's room, the resident was lying in bed with a wound vac connected. During an observation on 3/16/2026 at 8:50 a.m. outside Resident 52's room, no EBP sign was posted. During an interview on 3/18/2026 at 12:50 p.m. with Infection Preventionist (IP), IP stated that enhanced barrier precautions (EBP) are implemented when residents have a wound vac in place. The IP further explained that failing to use proper Personal Protective Equipment (PPE) when entering and exiting a resident's room can contribute to the spread of infections and bacteria. 4.During a review of Resident 10's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included left arm fracture (a break in the bone), falls, and cellulitis (skin infection) of the left arm. During a review of Resident 10's History and Physical (H&P), dated 12/26/2025, the H&P did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicate if the resident has the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/23/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). During a review of Resident 10's physician orders included an order dated, 12/25/2026, for Bisacodyl (medication used to treat constipation) Suppository 10 MG (milligram, a unit of measuring weight) Insert 1 suppository rectally every 24 hours as needed for Bowel Care. During a review of Resident 10's physician orders included an order dated, 12/25/2026, for Calcium Carbonate Tablet chewable 500 MG (milligram, a unit of measuring weight) to be give 1 tablet by mouth two times a day for indigestion. During a medication administration observation and interview on 3/17/2026 at 9:24 AM with LVN 2 inside Resident 10's room, LVN 2 stated he will not administer Resident 10's bisacodyl suppository. LVN 2 donned a new pair of gloves and assisted Resident 10 to lay on the bed. With LVN 2's right hand, LVN 2 inserted the bisacodyl suppository inside Resident 10's anus. Once the medication was inserted by LVN 2, LVN 2 assisted Resident 10 back into a sitting position and helped the resident sit on a chair beside the resident's bed. During a medication administration observation and interview on 3/17/2026 at 9:32 AM with LVN 2 inside Resident 10's room, LVN 2 stated he will now administer Resident 10's calcium carbonate. LVN 2 removed the gloves that were used to administer the bisacodyl, but LVN 2 did not perform hand hygiene. LVN 2 then grabbed the medication cup which contained calcium carbonate. On 3/17/2026 at 9:32 AM, LVN 2 was instructed by the surveyor to stop the administration of calcium carbonate. During an interview on 3/17/2026 at 9:37 AM, LVN 2 stated that he wore gloves when he administered Resident 10's bisacodyl. LVN 2 stated that he forgot to perform hand hygiene after administering Resident 10's bisacodyl. During an interview on 3/19/2026 at 9:53 AM with the Infection Preventionist Nurse (IP), the IP stated that staff must wash hands or use a hand sanitizer after administering a suppository even if gloves were used. The IP stated that the gloves that were used during the administration of suppositories might be infectious. The IP further stated that failing to perform hand hygiene could cause infections. During an interview on 3/19/2026 at 10:00 AM with the Director of Nursing (DON), the DON stated that staff should perform hand hygiene after administering a suppository. The DON stated that even if the nurse removes the used gloves after the administration of a suppository, the nurse must still wash (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their hands or use a hand sanitizer. The DON further stated that not performing hand hygiene places the resident at risk for potential infections such as gastrointestinal infections. During a review of the facility's policy and procedure (P&P), titled Medication Administration Rectal Suppositories, dated 1/2019, the P&P indicated the following sequence of procedures to the administration of a suppository: 4. Put glove on right or left hand. 7. Insert suppository gently into rectum beyond sphincter about 3 inches. 15. Wash hands. During a review of the facility's P&P, titled Medication Administration, dated 1/2019, the P&P indicated that hands are washed with soap and water before and after administration of topical, ophthalmic (through the eyes), otic (through the ears), parenteral (through injection), enteral (through the mouth), rectal, and vaginal medication, and with any resident contact. During a review of the facility's P&P titled, Infection Control, revised 4/2025, the P&P indicated that it is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. The P&P also indicate that standard precautions are infection prevention practices that apply to the care of all residents. The P&P indicated that standard precautions include hand hygiene.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure informed consent was obtained prior to the use of psychotropic medications for one of eight residents (Resident 17) in accordance with the facility's policy and procedure titled Chemical Restraints and Psychotropic Medication Management. This deficient practice had the potential to violate resident' rights to be informed prior to administering medications without their knowledge or approval. This also placed the resident to be at risk for unnecessary chemical restraint that limit their ability to participate in care decisions. Findings: During a review of the admission Record (AR) indicated Resident 17 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental health condition that includes hallucinations or delusions along with mood disorder symptoms), bipolar disorder (extreme mood swings), and insomnia (sleep disorder where a person has difficulty falling asleep or remaining asleep) . During a review of Resident 17's Minimum Set Data (MDS- a federally mandated resident assessment tool) dated 1/22/2026, indicated resident had moderated cognitive impairment, meaning resident has some problems with memory and thinking, but is still able to participate in care decisions to a degree. During a review of the Physician's Order report indicated to give Resident 17 the following: Abilify (Aripiprazole - antipsychotic [medication used to treat mood and behavioral disorders]) 5milligrams (mg) give 1 tablet by mouth every 12 hours for psychosis (seeing people that aren't there), dated 01/20/2026. Divalproex Sodium (mood stabilizer) Oral Tablet Delayed Release 250milligrams (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood stabilizer (excessive mood swings), dated 01/20/2026. Duloxetine (antidepressant-medication used to treat severe sadness and hopelessness) Capsule 60milligrams (mg) give 1 capsule by mouth two times a day for Depression (Verbalization of hopelessness), dated 01/202026. Klonopin one milligram (a medication used to stabilize mood and causes sedation or sleepiness]) give 1 tablet by mouth every 8 hours for Anxiety (Verbalization of anxiousness), dated 01/20/2026. Trazodone (antidepressant) 100milligrams (mg) give 1 tablet by mouth at bedtime for depression dated, 01/202026. During a review of Resident 17's informed consent dated 01/20/2026, indicated the Physician obtained informed consent for Duloxetine, Trazodone and Abilify. The informed consent form included Resident 17's signature however, it did not include the date the resident signed, leaving the consent form incomplete. During a concurrent interview and record review on 03/18/2026 at 10:50AM with Director of Nursing (DON), a review of medication consents and physician orders was conducted. Concurrent review of consent forms for Duloxetine, Trazodone, and Ability showed the forms were signed, however, no date was documented, leaving the consents incomplete. The DON stated that for consent forms to be complete and valid, they must be both signed and dated, and if not complete, the validity of the consent is questionable. During another concurrent interview and record review on 03/18/2026 at 10:50 AM, the DON stated there was no documented evidence an informed consent forms for both Divalproex sodium and Klonopin were obtained from Resident 17 or the responsible party, if any. During an interview on 3/18/2026 at 11:15 AM, with Resident 17, Resident 17 stated she is missing consent for Klonopin and Depakote (used for behavioral symptoms). Resident 17 Stated, I was told they were not antipsychotic medications and did not need a consent. During an interview on 3/18/2026 at 11:20AM, with Director of Staff Development (DSD), DSD stated she was unable to produce the missing informed consent forms for Divalproex sodium and klonopin. The DSD stated both medications require informed consent and should have been completed on the day the medication was started to be administered. The DSD further stated the resident should date the consent form at the time of signing to ensure the form is complete and to verify when consent was obtained. During a review of the facility's policy and procedure (P&P) titled Chemical Restraints and Psychotropic Medication Management dated 12/2025, the policy indicated the facility is to ensure residents are free from chemical restrains imposed for purposes of discipline or convenience and that such (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications are only used to treat a specific , documented medical condition. Additionally, the policy stated the Social Services Director (SSD) or designee is responsible for reviewing new admissions to ensure informed consent is obtained prior to the initiation or psychotropic medications.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote one of six sampled residents (Resident 35) the right to choose and participate in decision making regarding diet preferences that was important to the resident. This deficient practice violated the resident's rights of Resident 35 that make choices that could result unplanned weight loss and decline in the quality of life. Findings: During a review of Resident 35's admission Record indicated Resident 35 was admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses that included congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), major Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN - high blood pressure). During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool) dated 1/19/2026, indicated Resident 35 was cognitively (thought process) intact. The MDS indicated that Resident 35 needed substantial/maximal assistance with shower/bathe self, toileting hygiene. Partial/moderate assistance with putting on/taking off footwear, lower/upper body dressing. Supervision or touching assistance with personal and oral hygiene. Set up or clean up assistance with eating. During a review of Resident 35's Order Summary Report dated 8/28/2025 indicated a physician order of No added salt diet easy to chew-level 7 texture (regular easy to chew for adults) thin liquids (water consistency) During a review of Resident 35's Care Plan Has Potential Nutritional Problem revised on 2/16/2026, indicated the goal to maintain adequate nutritional status as evidenced by maintaining weight. Care plan indicated to serve the resident with no added salt, regular texture, thin liquids consistency. During a concurrent observation and interview on 3/16/2026 at 10:10 AM Resident 35 had snacks at bedside a can of peanuts and a bag of pretzels, Resident 35 stated these were her favorite snacks. Resident 35 stated that her food was changed to baby puree food (smooth blended food - like mashed fruits, veggies or meats), and that she does not have chewing or swallowing problems. Resident 35 stated that the staff did not come to talk to her about the change of the texture of her food and that this change started a few months ago. Resident 35 stated that she has told staff numerous times that she does not like the puree texture of her food and has taken pictures to show the staff that she is receiving puree texture food that she does not like to eat. During a review of Resident 35's Speech Therapy treatment encounter notes dated 3/17/2026, indicated a swallowing evaluation was done to evaluate if Resident 35 was able to tolerate regular texture food. The swallowing evaluation indicated that Resident 35 demonstrated safe tolerance to regular texture and MD was made aware of Resident 35's speech therapy recommendation and the diet was upgraded to regular texture. During an interview on 3/18/2026 at 2:30 PM with the Director of Nurses (DON) stated that the facility could not find the reason why Resident 35 was placed on an easy chew-level 7 texture diet. DON stated that she could not find documentation from the physician, speech therapy, or staff of why the resident had a change from regular diet to the easy-chew texture food. During a review of the facility's policy and procedure (P&P) titled Food and Nutrition Services revised on 7/21/21, indicated that each resident's nutritional status is assessed on admission, and quarterly. P&P indicated that the care plan shall be updated and revised as appropriate. During a review of the facility's P&P titled Change in Condition revised on 12/2025, indicated that if at any time a change of condition occurs such as a change in ability to eat or drink the nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders. P&P indicated that the IDT will collaborate with the attending physician, resident and or resident representative to review the plan of care.

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	03/19/2026

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on observation, interviews, and record review, the facility failed to ensure that information essential for resident understanding-such as activity calendars, facility rules and regulations, and meal menus-was provided in the resident's preferred language for 1 of 1 sampled resident reviewed for language needs (Resident 18). This failure resulted in Resident 18 being unable to understand posted information about facility activities, meal options, and facility rules, despite having a documented preference for Mandarin and moderately impaired cognitive function. Findings: During a review of Resident 18's admission Record (AR), the AR indicated the facility admitted the resident on 12/10/2025 with diagnosis that included but not limited to fracture (broken bone) of tibia (bone between knee and ankle) and fall. During a review of resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2025, the MDS indicated Mandarin is Resident 18's preferred language. MDS indicated Resident 18 has moderately impaired cognitive/brain function. During an observation on 03/16/2026 at 9:38 am in Resident' 18's room, the March 2026 Activity Calander, facility information, rules and regulations and weekly meal menu posted on the wall in front of the resident's bed, were in English. During an interview on 3/16/2025 at 9:44 am with Resident 18 (with an interpreter via phone) the help of interpreter, Resident 18 stated she is not able to speak or read English. Resident 18 stated she is unable to read the facility rules, regulations, activity calendar and weekly meal menu posted in resident's room. During an interview on 03/17/2026 2:02 pm with Activity Director (AD), Activity Director stated Resident 18 use google translate whenever resident need to communicate with the facility staff. Per AD, AD and facility staff have used google translate whenever needed to communicate with the resident during resident's visit. During an interview on 03/18/2026 at 1:43 pm with LVN 4, LVN 4 stated the facility has a dedicated interpreter phone number that can be called to communicate with non-English speaking residents. LVN 4 and facility staff has used Google translation on occasions to. communicate with non - English speaking residents in the facility. During an interview on 03/18/2026 at 1:59 pm with Director of Nursing (DON), the DON stated the facility staff must use interpreter services to communicate with non-English speaking residents in the facility. The DON stated Google translation is not to be used by the facility staff per the facility policy. During a review of the facility's Policy and Procedure (P&P) titled Comprehensive Resident Centered Care Plan, reviewed 12/2025, the P&P indicated the facility inter disciplinary team will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident. The P&P indicated the facility will provide interpreter services for non-English speaking residents, if needed or appropriate.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the physician for the significant change of condition when one out of six sample residents (Resident 4) who had a decrease in appetite and was not assessed for weight loss from 2/27/2026 to 3/18/2026 in accordance with the policy and procedures titled Change In Condition. This deficient practice had delayed in the doctor being notified and Resident 4 not being reassessed for weight loss. Findings: During a review of Resident 4's admission Record Resident 4 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/26/2025, the BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 8 moderate cognition (thought process). The MDS indicated that Resident 4 needed setup or clean up assistance with eating. During a review of Resident 4's Order Summary Report dated 3/1/2026 indicated that Resident 4 had a physician order for Regular diet with thin liquids large meat/protein portion and fortified foods. During a review of Resident 4's Order Summary Report dated 11/6/2025 indicated that Resident 4 had a physician order for Diabetic Health Shake with meals for malnutrition risk poor intake with breakfast, lunch and dinner. During a review of Resident 4's Order Summary Report dated 11/21/2025 indicated that Resident 4 had a physician order for monitoring episodes of poor oral intake every shift. During a review of Resident 4's Care Plan (Has Potential Nutritional Problem) revised 2/16/2026, indicated to monitor and report to the physician as needed for any signs and symptoms of decreased appetite, and unexpected weight loss. During a review of Resident 4's Medication Administration Record (MAR) dated 3/17/2026 - 3/18/2026 indicated an intake of less than 50%. During a concurrent observation and interview on 3/18/2026 at 12:30 PM with Certified Nurse Assistant (CNA 2) during lunch, Resident 4 tray was picked up by CNA 2, the tray was observed with 0% meal intake and a protein health shake unopened. CNA 2 stated that she did not set it up protein health shake for Resident 4 because he did not like the protein shake. CNA 2 stated that she had not told the licensed staff that Resident 4 did not want to eat. During a concurrent observation and interview on 3/18/2026 at 1:00 PM with the Director of Nurses (DON) observed Resident 4's lunch tray and agreed that Resident 4 meal intake was 0% and that the protein health shake was unopened. DON stated that CNA 2 did not notify licensed staff that Resident 4 did not like the protein shake. DON verified that Resident 4 has had decrease appetite and that not eating his meal is a concerned and the attending physician should have been made aware. During a review of the facility's policy and procedure (P&P) titled Change In Condition revised on 12/2025, indicated that at any time if one of the team members recognizes a change in a residents ability to eat or drink, or in food intake the nurse will perform and document an assessment of the resident and will communicate with the provider to obtain new orders or interventions.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 and record review, the facility failed to prevent development of pressure ulcer (an area of damaged skin and tissue caused by prolonged unrelieved pressure) by ensuring one of three sampled residents (Resident 43), was repositioned every two hours per the physician's order. This failure had the potential to increase the risk in the resident developing a pressure ulcer. Findings: During a review of Resident 43's face sheet, the face sheet indicated the resident was admitted on [DATE], with the diagnoses that included Parkinson's disease (Parkinson's disease is a progressive neurological disorder that primarily affects movement. It is characterized by the degeneration of nerve cells in the brain, abnormalities of gait and mobility). During a review of Resident 43's Minimum Data Set (MDS- standardized, comprehensive assessment form used to record a resident's physical, mental, and social health status) dated 10/1/2026, the MDS indicated the resident has a moderate cognitive impairment (ability to think and reason) . The MDS indicated Resident 43 is at risk for developing a pressure ulcer and needs substantial/maximal assistance for repositioning (moving a person with limited mobility into different positions), During a review of Resident 43's physician's orders dated 2/20/2026, the order indicated Resident 43 was to be repositioned every two hours while in bed. During a review of Resident 43's Point of Care Response History record from 2/16/2026 to 3/17/2026, the record indicated Resident 43 was turned and repositioned three times a day.ˆ During multiple observations on 3/16/2026 at 8:55 a.m., 11:15 a.m. and 4:30 p.m., in Resident 43's room, Resident 43 was lying in bed on his back with the head of the bed elevated at a 45 degrees angle. During an interview on 3/17/2026 at 12:34 p.m. with Resident 43, Resident 43, stated he was always lying on his back and not assisted to reposition in bed. During an interview on 3/18/2026 at 10:36 a.m. with Director of Staff Development (DSD), DSD stated there were no logs to tracking systems or documentation when the residents are repositioned, Certified Nursing Assistants (CNA)s are required to reposition the residents, according to the physician's orders. DSD stated not repositioning the residents could a cause a pressure ulcer to develop or cause an active pressure to worsen. During a review of the facility's policy and procedure (P&P) titled, Skin and Wound Monitoring and Management, dated 12/2025, the P&P indicated nursing staff shall implement resident care plans according to physician's orders.

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	555796	A. Building B. Wing	03/19/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to do ongoing assessment, perform weekly weights and provide revised interventions for one of six sampled residents (Resident 4) who has had weight loss. This deficient practice placed the resident at risk for altered nutritional status and further weight loss. Findings: During a review of Resident 4's admission Record Resident 4 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/26/2025, the MDS indicated that Resident 4 was moderately cognitive (thought process) impaired. The MDS indicated that Resident 4 needed setup or clean up assistance with eating. During a review of Resident 4's Weights and Vitals Summary indicated equivalent to weight loss of 14.7 percent (%) weight loss in five (5) months as indicated in the following: On 9/24/2025 a documented weight of 147 pounds (lbs.) On 10/2/2025 a documented weight of 149 lbs. On 11/3/2025 a documented weight of 142 lbs. On 12/8/2025 a documented weight of 138 lbs. On 1/1/2026 a documented weight of 135 lbs. On 2/2/2026 a documented weight of 135 lbs. On 3/2/2026 a documented weight of 127 lbs. During a review of Resident 4's Order Summary Report dated 11/21/2025, indicated to monitor episodes of depression as evidence by poor oral intake every shift. During a review of Resident 4's Order Summary Report dated 2/27/2026, indicated an order for weekly weights for 4 weeks. During a review of Resident 4's Order Summary Report dated 3/12/2026, indicated an order for 4 ounces of sugar free ice cream two times a day with lunch and dinner. During a review of Resident 4's Nutrition interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) dated 3/12/2026 indicated that Resident 4's weight was below goal of 144-154 lbs. IDT recommendation was to add ice cream with lunch and dinner. During an interview on 3/18/2026 at 12:30 PM with the DON stated that Resident 4 did not eat his food and the percentage of the meal intake was 0%, DON stated that this change of condition should have been reported to the attending physician. During a concurrent observation and interview on 3/18/2026 at 1:00 PM with the Director of Nurses (DON) while observing Resident 4's lunch tray ice cream was not served with lunch. The DON stated that ice cream should have been served with the lunch meal as ordered by the physician. During an interview on 3/18/2026 at 1:10 PM with the DON, DON stated Resident 4 should have been on weekly weights as of 2/27/2026 for weight monitoring due to weight loss but was not performed. During a review of Resident 4's care plan Has Potential Nutritional Problem revised date 2/16/2026, indicated that Resident 4 eats less than 50% offer meal replacement, monitor and report to the attending physician as needed for any signs/symptoms of decreased appetite. During a review of the facility's policy & procedures (P&P) titled Food and Nutrition Services revised date on 7/21/2021, indicated that the facility will be monitoring and evaluating the resident's response to the interventions, especially when there is no progress toward the nutritional goal. The P&P indicated that weekly weights are entered into the electronic health record in the weights and vital signs.

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	555796	A. Building B. Wing	03/19/2026

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper maintenance of an intravenous (IV) site for 1 of 8 sampled residents (Resident 25). Resident 25 was observed with a double^lumen midline catheter with an expired dressing and no Curos disinfecting cap in place. This deficient practice was inconsistent with the facility's Infection Control Policy - Intravenous Therapy, dated 12/2025, which required IV dressings to be dated and changed as scheduled and required cleansing or protection of the lumen port to prevent contamination. This failure had the potential to expose the IV site and lumen to contamination, increasing the risk for infection, including bloodstream infection and sepsis. Findings: During a review of Resident 25's admission Record (AR), it was noted the facility admitted the resident on [DATE] with diagnoses including sepsis, acute respiratory failure with hypoxia, and extended^spectrum beta^lactamase (ESBL) infection. During a review of Resident 25's Minimum Data Set (MDS), dated [DATE], indicated the resident had moderate cognitive impairment and was independent with bathing, dressing, toileting, and eating. During an observation on [DATE] at 12:06 p.m., Resident 25 was observed with a midline catheter. The dressing at the catheter insertion site was expired ([DATE]) and past the due date for change. No antiseptic (Curos) cap was present on the lumen of the catheter. During a concurrent observation and interview on [DATE] at 12:15 p.m. with the Director of Staff Development (DSD) in Resident 25's room, the midline dressing was observed with a date of [DATE] and no time documented. The DSD stated the dressing was to be changed weekly on Sundays and confirmed the dressing was past due. The DSD further stated the dressing must be dated to ensure timely changes and reduce the risk of infection. During a review of the facility's policy and procedure titled Infection Control Policy - Intravenous Therapy, dated 12/2025, indicated the policy's purpose was to provide guidelines for the prevention of infections associated with intravenous therapy. The policy stated that site care included marking the tape with the date and initials and placing it over the dressing. The policy further indicated the exterior lumen port must be cleansed with alcohol prior to disconnecting old tubing, connecting new tubing, and prior to removal and replacement of the Luer^lock cap.

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	555796	A. Building B. Wing	03/19/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and record reviews, the facility failed to ensure oxygen therapy was provided in accordance with physician orders and infection control practices for 2 out of 8 sampled residents (Resident 40 and 62) when: The oxygen tubing for Residents 40 and 62 was not dated or was past the facility's required replacement interval. The oxygen therapy for Resident 40 was observed not in place as ordered by the physician. The facility staff failed to consistently monitor and verify oxygen placement for a resident known to remove the nasal cannula. These deficient practices had the potential to result in residents not receiving prescribed oxygen therapy and exposure to infection risk from outdated or improperly maintained oxygen equipment. Findings: 1. During a review of Resident 40's admission Record, the admission Record indicated the facility admitted the resident on [DATE] with diagnoses including acute respiratory failure with hypoxia, asthma, and atrial fibrillation. During a review of Resident 40's Minimum Data Set (MDS), dated [DATE], the MDS indicated the resident had severe cognitive impairment and was totally dependent for activities of daily living, including eating, oral hygiene, toileting, and personal hygiene. During a review of Resident 40's care plan titled Has Oxygen Therapy r/t respiratory failure and asthma, dated [DATE], the care plan indicated a goal for the resident to have no signs or symptoms of poor oxygen absorption, with an intervention to administer oxygen as ordered by the physician. During a review of Resident 40's care plan titled At risk for altered respiratory status and difficulty breathing r/t respiratory failure, dated [DATE], the care plan indicated a goal for the resident to have no complications related to shortness of breath and no symptoms of poor oxygen absorption, with an intervention to provide oxygen as ordered. During a review of Resident 40's care plan titled Resident has episodes of removing the nasal cannula, dated [DATE], the care plan indicated a goal for the resident to cooperate with care, with an intervention to monitor episodes of removing the nasal cannula. During a review of Resident 40's Order Summary Report, dated [DATE], the Order Summary Report indicated the resident was to receive continuous oxygen at 2 liters per minute via nasal cannula, with instructions to maintain oxygen saturation above 90 percent every shift, for respiratory failure with hypoxia and asthma. 2. During a review of Resident 62's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses of atelectasis and sepsis. During a review of Resident 62's Minimum Data Set (MDS), dated [DATE], the MDS indicated the resident had moderate cognitive impairment and required touchˆonly assistance for eating and oral hygiene, and maximal assistance with personal hygiene. During a review of Resident 62's Order Summary Report, dated [DATE], the Order Summary Report indicated ipratropium-albuterol solution was to be administered by inhalation every four hours as needed for shortness of breath and wheezing via nebulizer. During an observation on [DATE] at 9:38 AM, Resident 62 was observed lying in bed with treatment tubing and a face mask on the bed. The tubing was labeled with a date of [DATE], indicating it was past the facility's replacement interval. During a concurrent observation and interview with the Infection Preventionist (IP) on [DATE] at 9:40 AM, the IP stated that oxygen tubing is to be changed weekly on Sundays. The IP confirmed the observed tubing was expired, stating that outdated tubing could lead to bacterial buildup and infection, and emphasized that tubing must be properly labeled to ensure timely replacement. During an observation on [DATE] at 9:57 AM, Resident 40 was observed lying flat in bed with oxygen not in place. The resident was holding the oxygen tubing on her chest. The tubing did not have a label indicating when it was last changed. During a concurrent observation and interview with the Director of Staff Development (DSD) on [DATE] at 10:05 AM, the oxygen tubing was observed not in the resident's nose and was not dated. RN1 stated that oxygen tubing should be dated to ensure timely replacement and identified the lack of labeling as an infection control concern. RN1 further stated that with the oxygen not in place, the resident may not be receiving the prescribed oxygen, which could result in desaturation. During an interview with Licensed Vocational Nurse (LVN 5) on [DATE] at 9:19 AM, (continued on next page)

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	555796	A. Building B. Wing	03/19/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 5 stated that Resident 40 frequently removes her nasal cannula. LVN 5 acknowledged that staff do not consistently verify that the oxygen remains in place after reapplication and stated that oxygen saturation is checked once per shift during routine vital signs at approximately 7:00 AM, 3:00 PM, and 11:00 PM, rather than at the time oxygen is found removed. During a review of the facility's policy and procedure titled Oxygen Therapy, revised 12/2025, the policy indicated that oxygen tubing is to be replaced every seven days or as needed when dirty or soiled, and that tubing is to be dated when changed. The policy stated oxygen is to be administered as ordered by the physician and addressed in the resident's plan of care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of two sampled residents (Resident 10) received correct dose of calcium carbonate (a dietary supplement that body needs to function and to treat indigestion or heart burn) as prescribed by the physician and in accordance with the facility's policy and procedure titled Medication Administration. This deficient practice placed Resident 10 at risk of ingesting more than the prescribed medication dosage or overdose which included symptoms such as constipation, nausea, vomiting, confusion and irregular heartbeat. Findings: During a review of Resident 10's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included left arm fracture (a break in the bone), falls, and cellulitis (skin infection) of the left arm. During a review of Resident 10's History and Physical (H&P), dated 12/26/2025, the H&P did not indicate if the resident has the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/23/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). During a review of Resident 10's physician order, dated, 12/25/2026, for Calcium Carbonate Tablet chewable 500 MG (milligram, a unit of measuring weight) to be give 1 tablet by mouth two times a day for indigestion. During a medication administration observation and interview on 3/17/2026 at 8:59 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed preparing Resident 10's calcium carbonate. LVN 2 stated he has a bottle of calcium carbonate 750 MG per tablet. LVN 2 stated he will cut the 750 MG per tablet into four quarters and administer only three of the four quarters (total of approximately 562.5 MG). LVN 2 proceeded to cut the calcium carbonate 750 MG per tablet into four quarters and put three of the four quarters into a medication cup. During a concurrent interview and record review on 3/17/2026 at 9:04 AM with LVN 2, Resident 10's medication order for calcium carbonate was reviewed. LVN 2 stated that the physician ordered Resident 10 to receive 500 MG tablet of calcium carbonate. During a medication administration observation and interview on 3/17/2026 at 9:32 AM with LVN 2 inside Resident 10's room, LVN 2 stated he will now administer Resident 10's calcium carbonate. On 3/17/2026 at 9:32 AM, LVN 2 was instructed by the surveyor to stop the administration of calcium carbonate. During a concurrent interview and observation on 3/17/26 at 9:32 AM with LVN 2, the medication containing the calcium carbonate was inspected. LVN 2 stated that the medication cup contained 562.5 MG of calcium carbonate, and not the prescribed dose of 500 MG. LVN 2 stated that he made a mistake when he prepared the medication. LVN 2 added that it is a medication error because the medication that he was about to give was 62.5 MG more than what was ordered by the physician. During an interview on 3/19/2026 at 10:00 AM with the Director of Nursing (DON), the DON stated that prior to preparing and administering medications, the nurse must first clarify if the medication's dose is correct. The DON also stated that all medications must be administered according to what was ordered by the physician. The DON also stated that if the wrong dose is administered, the medication might be ineffective or the resident could suffer an overdose (occurs when an individual consumes an excessive, toxic amount of a drug or substance, whether voluntarily or involuntarily, resulting in severe physical or mental harm). During a review of the facility's policy and procedure (P&P), titled Medication Administration, dated 1/2019, the P&P indicated that the administration of partial tablets is clearly identified or highlighted on the resident's MAR. The P&P indicated that medications are administered in accordance with written orders of the attending physician.

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	555796	A. Building B. Wing	03/19/2026

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review the facility failed to prevent unnecessary use of psychotropic medications (medications that affects mood and behavior) in accordance with the physician's order, and the facility's policy and procedure titled Chemical Restraints and Psychotropic Medication Management for two of the three sampled residents (Resident 6 and 61) by failing to ensure: 1.Resident 6 was monitored for the behavior indicated for the use of Abilify (antipsychotic medication given for psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality] and other behavioral mental health conditions) for one of six sampled residents. 2. Resident 61 was monitored for the side effects (undesired effect) and effectiveness of quetiapine fumarate (a medication that may be used to treat insomnia [a condition of having difficulty falling to sleep and/or remaining asleep) by documenting the presence of side effects if any and the resident's hours of sleep as indicated in the facility's policy and procedure (P&P) titled Chemical Restraints and Psychotropic Medication Management. This deficient practice had the potential to result in the residents receiving unnecessary medications or not sufficient dosage of medication to treat the behavioral disorder, and the potential to experience side effects with delayed or no treatment and prolonged use of the medication. Findings: 1.During a review of Resident 6's admission Record Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis. During a review of Resident 6's Minimum Data Set (MDS – resident assessment tool) dated 12/24/2025, indicated Resident 6 was moderate cognitive (thought process) impairment. The MDS indicated that Resident 6 was dependent on putting on/taking off footwear, lower body dressing, shower/bathe self, toileting hygiene. Substantial/maximal assistance personal hygiene, upper body dressing, oral hygiene and supervision or touching assistance with eating. During a review of Resident 6's Order Summary Report dated 3/1/2026, indicated a physician order for Abilify15 milligrams (mg- metric unit of measurement) once a day for psychosis for hearing voices that are not there. During a review of Resident 6's Medication Administration Record (MAR) from dated 3/1/2026 to 3/15/2026, indicated Resident 6 had received Abilify 15 mg once a day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's Care Plan (Anti-psychotic Medication Use) the care plan indicated that Resident 6 will show decreased episodes of signs and symptoms of psychosis through the review date. During a review of Resident 6's Psychiatry Evaluation dated 2/19/2026, indicated that Resident 6 was going to continue with medication for symptom management and medication adjustment was not indicated. The evaluation indicated to continue to monitor behavior. During a review of Resident 6's Psychiatry Evaluation dated 2/19/2026, the evaluation did not indicate the specific behavior to monitor. During a record review and concurrent interview on 3/18/2026 at 2:53 PM with the Director of Nurse (DON) stated that the monitoring of Resident 6's psychotic behavior of hearing voices that are not there should have been monitored and documented. The DON confirmed that there was no documented evidence indicating that Resident 6's symptoms of hearing voices that are not there were monitored and documented. The DON stated the importance of monitoring the behavior was to determine if the medication dosage could be reduced or discontinued the medication and to guide clinical decisions and ensure residents do not receive unnecessary medications. During a review of the facility's policy and procedure (P&P) titled Chemical Restraints and Psychotropic Medication Management revised date 12/2025, indicated that residents who use psychotropic drugs receive gradual dose reduction (GDR – a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued). The P&P indicated that the licensed nurses would review its indication, behavior monitoring, and related adverse side effects. 2. During a review of Resident 61's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included falls, Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills), and left leg fracture (a break in the bone). During a review of Resident 61's History and Physical (H&P), dated 3/13/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 61's physician orders, the orders included an order, dated 3/12/2026, for quetiapine fumarate (a medication that may be used to treat difficulty in sleeping) tablet 25 MG (milligram, a unit of measuring weight) given one tablet by mouth at bedtime for insomnia (difficulty sleeping or remaining asleep). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Medication Administration Record (MAR) for 3/2026, the MAR did not have documented evidence that Resident 61's hours of sleep was being monitored. During a review of Resident 61's progress notes since admission to 3/16/2026, the progress notes did not have documented evidence that Resident 61's hours of sleep was being monitored. During a review of Resident 61's care plan for mood disorder, dated 3/16/2026, the care plan included interventions for staff to administer medications as ordered and to monitor the side effects and effectiveness. During a review of Resident 61's consent form titled, Consent for Treatment: Use of Anti-Psychotropic Medication, dated 3/12/2026, the form indicated that quetiapine was ordered for the treatment of Resident 61's insomnia [manifested by the] inability to fall asleep. The form also indicated that the expected benefit of the medication was to increase the resident's hours of sleep. The form also indicated that on the section titled, expected duration of medication therapy, the administration of [the] medication will only continue as long as necessary. During a concurrent interview and record review on 3/16/2026 at 2:14 PM with Licensed Vocational Nurse (LVN) 3, Resident 61's medical records were reviewed, including the MAR and progress notes. LVN 3 stated that the records did not have documented evidence that Resident 61's hours of sleep were being monitored. LVN 3 stated that Resident 61's hours of sleep should have been monitored to identify if the resident's quetiapine is effective or not. LVN 3 also added that monitoring the hours of sleep could aid the facility in identifying if the medication was causing the resident to have side effect of excessive drowsiness, which could indicate a discontinuation of the medication. During another concurrent interview and record review on 3/16/2026 at 2:14 PM LVN 3, Resident 61's medical records were reviewed, including the consent form for Resident 61's quetiapine. LVN 3 stated that the consent form indicated that quetiapine was ordered for Resident 61's insomnia, that required monitoring and documenting Resident 61's hours of sleep as a tool to gauge if the medication is effective and still necessary to treat insomnia. During an interview on 3/19/2026 at 10:00 AM with the Director of Nursing (DON), the DON stated that if a medication is ordered to help the resident sleep, then the resident's hours of sleep should be monitored. The DON stated that monitoring the hours of sleep helps the facility know if the medication is working or not. The DON added that if the medication is not working, then the medication could be unnecessary and must be discontinued. The DON further added the monitoring the hour of sleep also helps the facility in knowing if the medication is affecting the resident too much, such as when a resident appears drowsy, which may indicate a need to reduce the dose of the medication. During a review of the facility's policy and procedure (P&P) titled, Chemical Restraints and Psychotropic Medication Management, undated, the P&P indicated that the licensed nurse shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related side effects prior to verification of admission orders with the attending physician. The P&P also indicated that the interdisciplinary team will review to ensure monitoring for adverse consequences and effectiveness of medications are in place.

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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 record review, the facility failed to follow their policies and procedures (P&P) for the proper storage and disposal of medications for two of three Medication Carts (MC 1) by failing to ensure: 1.A used syringe (a medical instrument consisting of a small, hollow tube, a plunger, and usually a needle, designed to inject fluids into or withdraw fluids from the body) was not left on top of MC 1's waste container. 2. An unlabeled small white pill was not left on top of the medication cart This failure had the potential for the residents to take and ingest the medication and the potential to expose residents, visitors, and staff to the unsecured items in the MC. Findings: 1.During an observation on 3/18/2025 at 10:10 am, in the facility hallway, Licensed Vocational Nurse (LVN) 3 left the medication cart to enter a resident's room. There was an unlabeled small white pill on top of the medication cart. During an interview on 3/18/2025 at 10:10 am with LVN 3, LVN 3 stated she could not identify the white pill. LVN 3 stated if someone were to ingest the white pill it could cause harm to that individual. During an interview on 3/28/2025 at 1:59 pm, with the Director of Nursing (DON), the DON stated all medications should be locked with only authorized staff having access to the medications. If any unauthorized individual could have used that unlabeled pill, the pill could have harmed that individual. During the review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated 1/2019, the P&P indicated the medication supply to be accessible only to the licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer the medications. 2.During an inspection of the facility's medication cart (MC) 1 on 3/16/2026 at 12:40 PM, MC 1 contained a pharmaceutical waste container on the right side of MC 1. The top of the waste container lid had a syringe. The syringe was visible and could be taken out of the waste container by hand. The syringe was not secured inside of the waste bin. During a concurrent observation and interview on 3/16/2026 at 12:42 PM with Licensed Vocational Nurse (LVN) 3, a syringe was observed on top of the waste container. LVN 3 stated that there was a syringe on top of the waste container, and LVN 3 added that the syringe was a medication that she administered. LVN 3 stated that the syringe should not be there because it is easily accessible to residents and visitors. LVN 3 further added that the syringe must be inside the waste container. During an interview on 3/19/2026 at 10:00 AM with the Director of Nursing (DON), the DON stated that (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses must throw used syringes inside of waste containers. The DON added that the used syringes could contain infectious material that could spread infections to residents. During a review of the facility's policy and procedure (P&P) titled, Disposal of Medications, Syringes, and Needles, dated 1/2019, the P&P indicated that used syringes and needles are disposed of safely and in accordance with applicable laws and safety regulations. The P&P also indicated that immediately after use, syringes and needles are placed into puncture resistant, one-way containers specifically designed for that purpose. The P&P also indicated that disposal containers are fitted with a lid that prohibits reaching into the container.

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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, interview and record review, facility failed to maintain a clean and sanitary physical environment in one of one staff-use emergency safety areas observed, the laundry room eye wash station. This failure had potential to compromise staff safety during emergency use of the eyewash station (an emergency area used to flush the eyes readily available with clean and appropriate temperate water in case of facility staff getting exposure to hazardous chemicals or irritants). Findings: During an observation on 03/17/2026 at 9:16 am, in the facility's laundry area, the eye wash station was observed with green and black stains on the basin surface. During an interview on 03/17/2026 at 9:41 am, with the Housekeeping/Laundry Supervisor (HS), the HS stated that using a dirty eye wash station could lead to an eye infection in staff. During an interview on 03/18/2026 at 1:59 pm, with the Director of Nursing (DON), the DON stated if staff use an unclean eye wash station during an emergency, it could worsen an eye injury or irritation. During a review of facility's policy and procedure (P&P) titled, Maintenance Policy dated 12/2025, the P&P indicated to maintain safe, clean, and functional environment for residents, staff, and visitors, the facility was required to conduct routine inspection of eye-wash stations, electrical and fire safety systems.