STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056076	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Terrace Care Center	141 South Knott Avenue Anaheim, CA 92804

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on interview, medical record review, and facility P&P review, the facility failed to follow up on the grievance for one of 22 final sampled residents (Resident 25). This failure had the potential for violating the resident's rights to have their grievances resolved. Findings: Review of the facility's P&P titled Grievance/Concern effective 8/25/21, showed the grievances are documented and tracked through to their conclusion. Also, the grievances are to be resolved promptly. On 6/11/24 at 0935 hours, a concurrent observation and interview was conducted with Resident 25. Resident 25 verbalized he had talked to the Administrator months ago about his Sketchers brand shoes being shrunk after being washed in the facility's laundry. Resident 25 stated he had also talked to the Administrator about wanting a reimbursement for his shrunken Sketchers shoes, but the Administrator still had not resolved his grievance. Resident 25 verbalized he also wanted a replacement for his two pairs of socks that were missing. Medical record review for Resident 25 was initiated on 6/11/24. Resident 25 was readmitted to the facility on [DATE]. Review of Resident 25's History and Physical examination dated 10/9/23, showed Resident 25 had no cognitive impairment. On 6/13/24 at 0840 hours, an interview was conducted with the Administrator. When asked about Resident 25's grievance related to his shrunken shoes, the Administrator stated he remembered talking to Resident 25 about the resident's shrunken shoes shrunk, but no further follow up was conducted. The Administrator stated he did not document the grievance verbalized by Resident 25.

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed for one of 22 final sampled residents (Resident 393). * The facility failed to develop the comprehensive resident-centered care plan to address the use of oxygen for Resident 393. This failure placed the resident at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed the purpose of an individualized comprehensive care plan includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs, and shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being. Medical record review for Resident 393 was initiated on 6/10/24. Resident 393 was admitted to the facility on [DATE]. Review of Resident 393's Order Summary Report showed a physician's order dated 6/5/24, for oxygen to be administered at 2 to 3 liters per minute as needed to keep the oxygen saturation levels above 90%. On 6/10/24 at 0948 hours, an observation and concurrent interview was conducted with LVN 1. Resident 393's nasal cannula was observed lying on the floor. LVN 1 verified the findings and stated Resident 393's nasal cannula needed to be stored in a clean bag for infection control and not on the floor. On 6/12/24 at 0920 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. Review of Resident 393's Medication Administration Record dated 6/5/24 at 1650 hours, showed Resident 393 received the oxygen therapy which was administered at 2 to 3 liters per minute to maintain the oxygen saturation levels above 90%. Review of Resident 393's medical record failed to show a comprehensive care plan was developed for the use of the oxygen. The MDS Coordinator verified the findings and stated the nurse who obtained the oxygen order should have initiated a comprehensive care plan to ensure Resident 393's plan of care was comprehensive, accurate, and included the monitoring of the oxygen usage.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure three of 22 final sampled residents (Residents 25 and 93) attained and maintained their highest practicable well-being. * The facility failed to ensure Resident 93's medication order for Insulin Regular Human (Regular Insulin is a short-acting type of insulin) Injection Solution per sliding scale was administered as ordered by the physician. This failure posed risk for Resident 93 to have hyperglycemic episode and to receive unnecessary short acting insulin dose. * Resident 25's change in skin integrity were not assessed and documented. This failure posed the risk of Resident 25 not receiving appropriate care. Findings: 1. Medical record review for Resident 93 was initiated on 6/3/24. Review of Resident 93's H&P examination dated 6/3/24, showed the resident had a capacity to understand and make decisions. Review of Resident 93's Physician Order Summary Report showed an order dated 6/3/24, for Regular Human Insulin per the following sliding scale three times a day: - For blood sugar (BS) below 70 mg/dl call MD - BS 0 - 150 mg/dl = 0 unit - BS 151 - 200 mg/dl = 2 units subcutaneously - BS 201 - 250 mg/dl = 4 units subcutaneously - BS 251 - 300 mg/dl = 6 units subcutaneously - BS 301 - 350 mg/dl = 8 units subcutaneously - BS 351 - 400 mg/dl = 10 units subcutaneously - BS greater than 400 mg/dl 12 units subcutaneously and call MD, Review of Resident 93's MAR for June 2024 showed the blood sugar check for 6/8/24 at 0630 hours, was not done or blank. Review of the MAR failed to show documentation the blood sugar check was held for any reason. Further review of MAR showed on 6/8/24 at 1130 hours, Resident 93's BS level was 379 mg/dl, and 10 units of Regular Human Insulin was administered to Resident 93. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 1513 hours, an interview with LVN 7 was conducted. LVN 7 verified the blood sugar check on 6/11/24, was blank or no documentation. LVN 7 stated the licensed nurses were expected to document the blood sugar results and administer Regular Human Insulin per sliding scale as ordered. On 6/13/24 at 1445 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. 35346 2. Review of the facility's P&P titled Skin Integrity management effective 5/26/21, showed an intervention to a resident's skin integrity management included staff continually observing and monitoring residents for changes and performing skin inspections weekly. On 6/11/24 at 0935 hours, a concurrent observation and interview was conducted with Resident 25. Resident 25 verbalized he had difficulty putting on his socks. Resident 25 was observed using his right index and middle fingers to remove his socks. Resident 25's left foot was observed with red colored skin tears to the top and left side of his foot, two horizontal marks to the top of his foot, scattered dryness and brown discoloration at the top of his foot, and brown discoloration to the side of his foot. Resident 25's right heel was observed with redness and the formation of a blister. In addition, Resident 25 was observed with yellow colored, long toenails extending beyond the edge of his toes. On 6/11/24 at 1050 hours, a concurrent observation, medical record review, and interview was conducted with CNA 4 and LVN 6. LVN 6 verified the above findings. When asked about assessing Resident 25's skin, LVN 6 stated last month was the last time Resident 25's head to toe skin inspection was completed. Review of Resident 25's weekly progress notes with LVN 6 failed to show documented evidence of any injuries or changes of skin integrity. On 6/11/24, at 1520 hours, an interview was conducted with Resident 25's assigned CNA (CNA 4). CNA 4 verified Resident 25's last shower was on 6/11/24. When asked about Resident 25's skin, CNA 4 stated she did not see any changes to Resident 25's skin integrity. Medical record review for Resident 25 was initiated on 6/11/24. Resident 25 was readmitted to the facility on [DATE]. Review of Resident 25's History and Physical examination dated 10/9/23, showed Resident 25 had no cognitive impairment. Further review of this examination form showed Resident 25's diagnoses included peripheral vascular disease for the bilateral lower extremities. Review of Resident 25's progress notes showed a medical specialist note dated 6/3/24, with Resident 25's diagnoses including left knee contracture, post status stroke with left side paralysis, tremors, and cellulitis of left lower extremity. Resident 25's plan of care included to perform daily skin checks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 1630 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the changes of Resident 25's skin were not documented to show they were observed and assessed and reported to Resident 25's physician for further follow up. There was no documented evidence a weekly skin head to toe assessment was completed for the resident and identified the impairment in the resident's skin integrity.

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure the oxygen therapy equipment was stored in a sanitary manner for one of two sampled residents reviewed for oxygen therapy (Resident 393). * Resident 393's nasal cannula was observed lying on the floor. This failure posed the risk for equipment contamination and respiratory complications. Findings: Medical record review for Resident 393 was initiated on 6/10/24. Resident 393 was admitted to the facility on [DATE]. Review of Resident 393's Order Summary Report showed a physician's order dated 6/5/24, for oxygen to be administered at 2 to 3 liters per minute as needed to keep the resident's oxygen saturation levels above 90%. On 6/10/24 at 0922 hours, an observation was conducted of Resident 393. Resident 393 was observed lying in bed. Resident 393's nasal cannula was observed wrapped around the call light cord. On 6/10/24 at 0948 hours, an observation and concurrent interview was conducted with LVN 1. Resident 393's nasal cannula was observed lying on the floor. LVN 1 verified the findings and stated Resident 393's nasal cannula needed to be stored in a clean bag for infection control and not on the floor. Cross reference to F656.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on interview and medical record review, the facility failed to ensure one sampled residents (Resident 35) reviewed for dialysis treatment received the dialysis treatment at the prescribed time. * Resident 35's transportation issues were not followed up on with the resident's insurance carrier. This failure had the potential for negative health outcomes for the resident. Findings: On 6/11/24 at 0813 hours, an interview was conducted with Resident 35. Resident 35 stated on 6/11/24, Resident 35 had an appointment to change his dialysis access site to a shunt. Resident 35 further stated his appointment was at 0800 hours on 6/11/24, and the transportation did not arrive to the facility until 0750 hours. Resident 35 stated he cancelled the appointment because the transportation was too late since his appointment was at 0800 hours and there was not enough time to get Resident 35 to his appointment location by 0800 hours. Resident 35 further stated last Friday, he did not get his dialysis until 1300 hours, which was late, and he was scheduled to receive his dialysis on Mondays and Fridays at 0415 hours and was supposed to be picked up between 0300 and 0330 hours, in order to ensure he would arrive on time to receive his dialysis treatments. Resident 35 stated he did not eat last Friday because he was prepared to be picked up on time for his dialysis appointment scheduled at 0415 hours. Resident 35 stated by the time he got back to the facility from his dialysis treatment last Friday, he was exhausted and not hungry. Resident 35 stated his body was already used to getting his dialysis treatments at 0415 hours, and it took a lot from his body to try to adjust to getting dialysis at different times. Resident 35 further stated these transportation issues happened multiple times. On 6/11/24, at 1608 hours, an interview was conducted with the Social Services Director. The Social Services Director verified there had been issues with Resident 35's transportation. When asked about following up to resolve the transportation issues, the Social Services Director stated staff called the transportation drivers about the issues related to the transportation not showing up on time to take Resident 35 to his dialysis and other appointments. On 6/11/24, medical record review was initiated for Resident 35. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 2/11/24, showed Resident 35's diagnoses included renal failure, diabetes, and high blood pressure. Review of Resident 35's June 2024 Order Summary Report showed an order dated 5/27/24, for Resident 35 to receive dialysis on Mondays and Fridays with pickup time of 0315 hours, and chair time 0415 hours. Review of the facility's email correspondence dated 4/19/24, showed to get urgent solutions for Resident 35's transportation problems. The facility was to call the customer service line for Resident 35's insurance carrier. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's progress notes showed the following issues related to Resident 35's transportation: - On 6/11/24, transportation was late. - On 6/7/24, transportation was a no show. - On 6/3/24, transportation from the resident's appointment location had to be rescheduled. - On 5/27/24, transportation was a no show. On 06/12/24, at 0843 hours, a telephone interview was conducted with Resident 35's customer service insurance carrier. When asked if any staff member from the facility had called to file a grievance in relation to Resident 35's transportation, the customer service agent verbalized nobody had called to file any grievances. On 6/12/24, at 1426 hours, an interview was conducted with the DON. When asked about the plan for ensuring Resident 35 had transportation to pick the resident up on time, the DON verbalized their plan was to have a back up transportation. On 6/18/24, at 1018 hours, a telephone interview was conducted with Resident 35. Per Resident 35, transportation for his scheduled dialysis appointment on 6/17/24 at 0415 hours, did not show up. Resident 35 verbalized again that he ended up getting his dialysis treatment at 1300 hours, instead of his schedule at 0415 hours. Resident 35 stated when he got back from dialysis yesterday he was not very hungry because dialysis treatments had physically exhausted him. Resident 35 stated he did not have breakfast or lunch yesterday 6/17/24. Resident 35 verbalized wanting reliable transportation that arrived on time so he could receive his dialysis treatments at 0415 hours, as his body was already used to this time. Resident 35 stated he needed transportation staff that would escort him into his appointment locations as he was not able to ambulate.