| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056076 | A. Building<br>B. Wing | 08/07/2024 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0550<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on observation, interview, and medical record review, the facility failed to promote the dignity and respect for one of seven sampled residents (Resident 2).<br><br>* CNA 1 was observed standing over Resident 2 while assisting the resident to eat her meal. This failure posed the risk of not treating the resident with respect.<br><br>Findings:<br><br>Medical record review for Resident 2 was initiated on 8/7/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>On 8/7/24 at 0835 hours, CNA 1 was observed standing over Resident 2 while feeding the resident laying in the bed.<br><br>On 8/7/24 at 0840 hours, an interview was conducted with CNA 1. CNA 1 verified she was standing over while feeding Resident 1 in her bed. |

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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of sevensampled residents (Residents 6) could self-administer the medications safely.<br><br>* Resident 6 had a bottle of sealed Motrin (medication to relieve pain) 200 mg, a plastic medication cup containing one tablet of Oscal 500/200 with vitamin D (supplement), and two capsules of Docu Soft (stool softener) 100 mg inside the drawer of Resident 6's bedside table for self-administration. Resident 6 was not assessed for self-administration of medications. This failure had the potential to negatively impact the resident's physiological well-being, and administer the medications inaccurately.<br><br>Findings:<br><br>Review of the facility's P&P titled Self Administration of Medications (undated) showed the residents have the rights to self-administer themedications if the interdisciplinary team has determined that it is clinically appropriate and safe for the residents to do so. If it is deemed safe and appropriate for the residents to self-administer the medications, this is documented in their medical records and care plans. The decision that the residents can safely self-administer the medications are re-assessed periodically based on changes in the residents' medical and/or decision-making status. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.<br><br>On 8/7/24 at 1112 hours, an observation and concurrent interview was conducted with Resident 6. Resident 6 pointed to her bedside table and asked to pull the drawer from underneath the bedside table. The DSD assisted Resident 6 and pulled the drawer from Resident 6's bedside table as requested by Resident 6. Resident 6's bedside table drawer was observed with a plastic medication cup containing one green tablet and two red capsules. The DSD verified the presence of the medications in the medication cup. Resident 6 stated the green tablet was calcium and the two red ones were for her bowels. Resident 6 stated she knew the licensed nurse had to be present to make sure she took all of her medications; however, Resident 6 stated she did not want to take the medications all at once. Resident 6 stated she placed her medications inside the drawer underneath the bedside table after the licensednurse left the room. During the observation and concurrent interview with Resident 6 and with the DSD, one bottle of sealed Motrin 200 mg was also observed inside Resident 6's drawer underneath the bedside table. The DSD verified the findings and stated Resident 6 needed to be assessed to self-administer the Motrin, needed a physician's order for the medication, and could not keep the Motrin in the drawer at this time per thefacility's policy.<br><br>Medical record review for Resident 6 was initiated on 8/7/24. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 6's H&P examination dated 11/25/23, showed Resident 6 had the capacity to understand and make decisions.<br><br>Review of Resident 6's Order Summary Report dated 8/7/24, showed the physician's orders dated:<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 8/12/20, Oscal 500/200 D-3 500-200 mg-unit one tablet by mouth two times a day for supplement.<br><br>- 4/14/22, for Docu Soft Capsule 100 mg two capsules by mouth two times a day for bowel management, hold if with loose stool<br><br>On 8/7/24 at 1115 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DSD. The DSD verified the medications found inside Resident 6's bedside table drawer were Oscal 500/200 with vitamin D (one green tablet) and Docu Soft capsule 100mg (two red capsules). When asked if the medications were supposed to be stored in Resident 6's tray table drawer, the DSD stated, no. The DSD further statedthe licensed nurse was supposed to stay with the resident to make sure the medications were all taken before they leftthe room for safety.<br><br>On 8/7/24 at 1346 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 3. LVN 3 verified she did not stay the whole time with Resident 6 to finish taking her medications. LVN 3 further stated Resident 6 did not want to take the medications all at once and she should have stayed with the Resident 6 until the resident finished taking all her medications, and if Resident 6 did not want to take all her medications, then she should have discarded the medications and let Resident 6's physician know. LVN 3 stated she was informed by the DON about the medications that Resident 6 did not take. LVN 3 also verified there was no physician's orders, self-administration of medication assessment, IDT, and care plan for Resident 6 to self-administer medications. |

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| F 0558<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the call light was accessible for one of sevensampled Residents (Resident 6).<br><br>* Resident 6's call light was not within her reach. This failure had the potential to negatively impact Resident 6's psychosocial well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Answering the Call Light revised 9/2022 showed the purpose of this procedure is to ensure timely responses to the resident's requests and needs. The policy showed to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.<br><br>On 8/7/24 at 0828 hours, an observation and concurrent interview was conducted with Resident 6. Resident 6 was observed sitting in her wheelchair to the right side of her bed. Resident 6's call light was observed tied to the left handrail of the bed which was not within Resident 6's reach. When asked if Resident 6 was able to reach for her call light, Resident 6 stated no. Resident 6 stated she knew she needed to be able to reach it in case she needed help.<br><br>On 8/7/24 at 0834 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 stated the call light was supposed to be near the resident where they could reach it. When asked where Resident 6's call light was and if it was placed within Resident 6's reach, CNA 2 verified Resident 6's call light was not within the resident's reach. CNA 2 furtherstated she should have placed the call light near Resident 6 so she couldcall for help if needed.<br><br>Medical record review for Resident 6 was initiated on 8/7/24. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 6's H&P examination dated 11/25/23, showed Resident 6 had the capacity to understand and make decisions.<br><br>On 8/7/24 at 1512 hours, an interview was conducted with the DON. The DON was informed ofResident 6's call light was observed to not be within the resident's reach and the DON acknowledged thefinding. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on interview, medical record review, and facility document review, the facility failed to ensure one of seven sampled residents (Resident 2) was free from the physical abuse by another resident.<br><br>* Resident 2 was hit on the left shoulder and left side of the face by Resident 1. This failure had the potential to negatively impact the resident's well-being.<br><br>Findings:<br><br>Review of thefacility's P&P titled Abuse Prohibition Policy and Procedure reviewed 2/23/21, showed the facility prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The purpose of the policy is to ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. Appropriate interventions to deal with aggressive and/or catastrophic reactions of the patients. Actions to prevent abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property, will include: Identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur. The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected. The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The family and physician will be notified, and any follow-up recommended will be completed.<br><br>Review of the facility's P&P titled Behavior Management revised 2/1/23, showed resident exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the Resident's behavior. Based on the comprehensive assessment; staff must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Behaviors and interventions will be addressed in the care plan.<br><br>Review of Resident 1's closed medical record was initiated on 8/7/24. Resident 1 was admitted to the facility on [DATE], and was transferred to an acute care hospital on 7/28/24.<br><br>Review of the MDS admission assessment dated [DATE], showed Resident 1 was able to make self-understood and usually able to understand others. Review of Resident 1's BIMS summary score was 3 (severe cognitive impairment).<br><br>Review of Resident 1's H&P examination dated 7/13/24, showed the resident didnot have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 1's Change in Condition Evaluation Report dated 7/27/24 at 1457 hours, showed the resident was observed wandering in the hallway then suddenly, without provocation, Resident 1 pushed the charge nurse who was cleaning the cart and later pulled another staff's hair.<br><br>Review of Resident 1's General Notes dated 7/27/24 at 1936 hours,showed Resident 1 grabbed other residents' food trays then put into her room.<br><br>Further review of Resident 1's progress notes failed to show the physician was notified of Resident 1's continued change in behavior after grabbing other residents' food trays.<br><br>Review of Resident 1's Plan of Care failed to show a care plan was initiated to address the change in behavioral condition to provide interventionsfor the safety of Resident 1 and other residents in the facility.<br><br>Review of Resident 1's Change in Condition Evaluation Report on 7/28/24 at 1110 hours, showed behavioral status evaluation: physical aggression. Resident 1 was assisted back in her room and kept safe. Thereafter, theresident was asked for the reason for her behavior; however Resident 1 did not respond and just stared at the staff. Resident 1 had no body injuries after the incident.<br><br>Review of Resident 1's General Notes dated 7/28/2024 at 1129 hours, for late entry showed Resident 1 was walking along the hallway, then suddenly struck out at Resident 2 on the left side of the face who was seated outside her room by the doorway. There were two RNAs who were near Resident 2's room andwitnessed the incident. LVN 2 and RNAs 1 and 2 rushed to Residents 1 and 2 and separated them. Resident 1 was assisted back to her room.<br><br>Review of Resident 1's physician's orders showed an order dated 7/28/24, to transfer to anacute hospital psychiatric unit due to physical aggression and refusal of medications/care.<br><br>Medical record review for Resident 2 was initiated on 8/7/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 2's Change in Condition Evaluation Report dated 7/28/24 at 1110 hours, showed the nursing staff immediately rushed to the scene and separated Residents 1 and 2 immediately. Resident 2 was assisted back into her room. Resident 2 was observed with a slight redness to theleft side of her face. No bleeding or open areas were observed. Resident 2 complained of pain rating of 3 (on a 0-10 pain scale with 0 = no pain and 10 = worst pain) and was given Tylenol pain reliever) as ordered. Resident 2 had no change in level of consciousness. The neuro checks were initiated and ensured safety.<br><br>Review of Resident 2's General Notes on 7/28/24 at 1115 hours,showed Resident 2 was seated in her wheelchair outside her room by the doorway when Resident 1 passed by her and suddenly struck her byhitting her left face and shoulder. RNAs 1 and 2 were near Resident 2's room saw the two residents and called LVN 2. LVN 2 and two RNAs rushed to both residents and separated them right away.<br><br>On 8/7/25 at 0845 hours, an interview was conducted with Resident 2. Resident 2 stated she was hit on her face (pointing to the left side of her face) by a person she did not know. Resident 2 stated she had some vision difficulty on her left eye and had some buzzing noise in her left ear. Resident 2 further stated she did not fight back.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/7/24 at 1145 hours, an interview was conducted with CNA 1. CNA 1 stated she was aware Resident 1 was being monitored for walking around. CNA 1 stated it was difficult to redirect Resident 1 because she ignoredthe staff. CNA 1 further stated she was not aware that Resident 1 had an aggressive behavior on 7/27/24.<br><br>On 8/7/24 at 1151 hours, an interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 verified Resident 1's change in behavioral condition. LVN 1 stated Resident 1 did not communicate and ignored the staff. LVN 1 verified there was no plan of care initiated with Resident 1's change of condition (aggressive behaviors on 7/27/24) to prevent Resident 1 from harming other residents.<br><br>On 8/7/24 at 1348 hours, a telephone interview was conducted with RN 1. RN 1 stated Resident 1 was wandering and had the tendencyto get aggressive and resistive to care. RN 1 verified Resident 1 had a behavior change on 7/27/24, when Resident 1 pushed a nurse and pulled another staff's hair without provocation. Resident 1 had another incident later in the evening of grabbing other resident's meal trays. RN 1 stated she failed to initiate a care plan for a change in resident's behavior to interventions to prevent Resident 1from harming other residents.<br><br>On 8/7/24 at 1438 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated the licensednurses should have notified the physician for Resident 1's continued aggressive behavior for further interventions. Review of Resident 1's care plan with the DON failed to show resident's change in behaviors and interventions to prevent Resident 1 to harm self or other residents.<br><br>On 8/7/24 at 1450 hours, an interview was conducted with the Administrator. The Administrator stated the licensednurses should have notified the physician for further guidance to manage Resident 1's behavior.<br><br>On 8/7/24 at 1503 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 1 was being monitored for walking and wandering in the hallways; however, she was not aware of Resident 1's behaviors of pushing a nurse, pulling the hair of another staff, and grabbing the meal trays. LVN 2 stated Resident 1 was hard to redirect because Resident 1 ignored staff's redirection and would not say anything. LVN 2 stated she responded quickly when Resident 1 struck Resident 2. Residents 1 and 2 were separated. LVN 2 assessed Resident 2 and initiated neurologic check. Resident 2 was observed with redness on the left side of the face and complained of headache. Resident 1 was taken back to her room; however, still continued to walk around. |