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	01/15/2025

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 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of 13 sampled residents (Residents 8 and 13) attained and maintained the highest practicable physical well-being. * On 12/22/24, Resident 8 requested to continue the Ciprodex Otic suspension (used to treat middle ear infections) for continued ear pain after completing the seven-day treatment on 12/20/24. Resident 8 received the requested Ciprodex Otic suspension on 1/7/25, 16 days later. * The facility to ensure Resident 13's ceftriaxone sodium (antibiotic) intravenous medication was administered as per the physician's order. These failures had the potential to negatively affect residents' health condition and well- being. Findings: 1. Review of the facility's P&P titled Change in Condition dated 8/25/21, showed the facility must immediately inform the resident, consult with resident's physician and/ or nurse practitioner, and notify, consistent with his/ her authority, Resident Representative when there is a significant change in Resident's physical, mental, or psychosocial status in either life threatening conditions, or clinical complications; a need to alter treatment significantly (that is a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Review of Resident 8's medical record was initiated on 1/9/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 7/18/24, showed Resident 8 had the capacity to understand and make decisions. Review of Resident 8's Progress Note dated 12/22/24 at 1756 hours, showed the following entry by the licensed nurse: followed up request of continuation for eardrop antibiotics waiting for MD order. Further review of Resident 8's Progress Notes failed to show documentation of any follow up call to the physician was made regarding Resident 8's request for the ear drop antibiotics. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's Order Summary dated 1/9/25, showed a physician's order dated 1/6/25, to administer Ciprodex Otic suspension 0.3-0.1% two drops in both ears two times a day for ear pain for seven days with supervised self-administration. On 1/9/25 at 0851 hours, an interview was conducted with Resident 8. Resident 8 stated she had asked LVN 8 to extend the ear drops due to having continued ear pain. Resident 8 further stated she followed up with the LVN 8 every day, however, LVN 8 would tell the resident the physician had not replied. On 1/10/25 at 1108 hours, an interview was conducted with LVN 8. LVN 8 acknowledged Resident 8 continued to complain of ear pain after the Ciprodex Otic suspension treatment was completed on 12/20/24. LVN 8 verified there was no documentation to show follow up calls were made to notify the physician of Resident 8's ongoing complaint of ear pain after 12/22/24. LVN 8 verified a new physician's order for the Ciprodex Otic suspension was received on 1/6/25, 16 days after the resident requested to extend the Ciprodex Otic suspension because Resident 8's ear was observed with brown residue. On 1/15/25 at 0955 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to follow up with physician for any resident's request or change in condition. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 13 was initiated on 1/14/25. Resident 13 was admitted to the facility on [DATE] with diagnoses of herpes (viral infection causing painful blisters or ulcers) viral infection of the perianal skin and rectum. Review of Resident 13's Order Recap Report showed a physician's order dated 12/12/24, to administer the following: - ceftriaxone sodium (antibiotic) intravenous (IV) solution two grams every 12 hours for perineal lesions (damaged skin tissue caused by infection) until 12/21/24. Review of Resident 13's MAR for December 2024 showed missing documentation for the ceftriaxone medication scheduled to be administered on 12/12/24 at 2100 hours. On 1/15/25 at 0827 hours, an interview and concurrent medical record review was conducted with RN 1. Resident 13's MAR for December 2024 was reviewed with RN 1. RN 1 verified the missing documentation by the licensed nurse to show the ceftriaxone medication was administered to Resident 13 on 12/12/24 at 2100 hours. When asked what the missing documentation meant on Resident 13's MAR for the ceftriaxone medication, RN 1 stated, I'm not sure if the medication was given or not. RN 1 further stated all medication administration by the licensed nurse must be document in the MAR. On 1/15/25 at 0846, a follow up interview and facility document review was conducted with RN 1. When asked if the ceftriaxone medication was delivered by the pharmacy on 12/12/24, RN 1 stated the ceftriaxone medication was not delivered since the medication was not in the IV medication cart when she worked the morning shift on 12/13/24. RN 1 was asked to check the facility's emergency kit (Ekit) logbook if the ceftriaxone medication was removed from the Ekit. RN 1 verified there was no Ekit form filled out in the Ekit logbook for the ceftriaxone medication on 12/12/24. RN 1 stated for any medications removed from the Ekit, the licensed nurse needed to fill out the Ekit form after obtaining the authorization from the pharmacist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 0926 hours, an interview was conducted with Pharmacy Technician 1. Pharmacy Technician 1 stated Resident 13's ceftriaxone medication order was not processed for delivery on 12/12/24. On 1/15/25 at 0948 hours, an interview was conducted with RN 2. RN 2 stated she carried out Resident 13's admission orders on 12/12/24, however, RN 2 stated she did not administer the IV ceftriaxone medication. On 1/15/25 at 1057 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the missing documentation on Resident 13's MAR for the ceftriaxone medication on 12/12/24 at 2100 hours. The DON stated the medication was not administered since it was not documented. The DON stated the RNs must document in the MAR after the administration of any IV medications. The DON acknowledged the above findings.

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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 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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of three sampled residents (Resident 3, 4, and 5) reviewed for the use of respiratory care equipment was provided with the appropriate respiratory care. * The facility failed to ensure Resident 3's oxygen tubing was changed weekly and the CPAP mask was stored in a dated set-up bag when not in use. * The facility failed to ensure Resident 4's Yankauer tip suction was clean and stored according to the facility' P&P. * The facility failed to ensure Resident 5's oxygen tubing was stored in a bag and changed weekly as ordered by MD. Findings: 1. Medical record review for Resident 3 was initiated on 12/11/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident's Order Summary Report from 9/6/24 to 12/31/24 showed the following orders: - dated 9/20/24, CPAP Pressure: CPAP:8 Back-Up Rate: 20 Oxygen Liter Flow (for bleed in): 2 LPM remove in AM and Apply at HS Interface type: Nasal Pillows/Mask/ Full face mask Humidification (if appropriate) Heated or Cool Fill humidifier with sterile or distilled water. ON HS/OFF AM CPAP - dated 9/20/24, CPAP USE at bedtime for Sleep Apnea - dated 9/20/24, CPAP: Change or clean intake filter and disposable supplies per manufacturer's guidelines or if soiled. - dated 9/20/24, CPAP: Change or clean Intake filter and disposable supplies per manufacturer's guidelines or if soiled. as needed and every Saturday. - dated 11/15/24, oxygen via nasal cannula at 2 LPM as needed for to keep oxygen saturation above 90%. On 12/11/24 at 1006 hours, Resident 3's oxygen tubing was observed in a bag dated 11/24/24. The CPAP mask and tubing were observed partially stored in an opened bag and the CPAP mask was hanging out of the bag. Resident 3 stated he used the CPAP at night and the staff stored them. On 12/11/24 at 1008 hours, an interview was conducted with LVN 2. LVN 2 verified Resident 3's oxygen tubing was in a bag dated 11/24/24, and verified the findings. (continued on next page)

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Review of facility's P&P titled Suctioning dated 8/2014 showed in part, the suction tubing may be intermittently flushed with hydrogen peroxide to remove and decontaminate secretions inside connecting tubing. When the suction equipment is designated for a particular resident for extended use, suction, connecting tubing and suction collecting canister need not be discarded on a regular schedule but should be cleaned and flushed as necessary when secretions are present. If the suction connecting tubing becomes visibly soiled with secretions that will not flush, new tubing may be attached. The suction collection canister should be emptied and cleaned daily and changed or decontaminated as necessary. Review of Resident 4's medical record was initiated on 12/11/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident's 4's Order Summary Report showed an order dated 7/28/24, may suction for excessive secretion. On 12/11/24 at 0947 hours, Resident 4 was observed with the suction machine at bedside. The Yankauer tip suction was in a bag dated 9/21/24, inside the nightstand drawer with part of tubing hanging off the nightstand not connected to the suction canister. The canister was observed with brownish dried residue. The Yankauer tip was observed with thick brownish dried secretion. On 12/11/24 at 0952 hours, an interview was conducted with the IP. The IP verified the canister had brownish dried residue and the Yankauer tip had thick brownish dried secretion. The IP stated the equipment needs to be changed. 3. Review of Resident 5's medical record was initiated on 12/11/24. Resident was initially admitted on [DATE] and was readmitted on [DATE]. Review of Resident 5's Order Summary Report as of 12/11/24 showed the following orders: - dated 7/11/24 Oxygen at 2-5 LPM via nasal cannula as needed for shortness of breath - dated 7/11/24 Change oxygen tubing weekly On 12/11/24 at 0954 hours, Resident 5's nasal cannula was observed exposed and hanging over the side rails in between the urinal. A bag was stored in the oxygen concentrator dated 12/1/24. On 12/11/24 at 1006 hours, an interview was conducted with LVN 8. LVN 8 verified Resident 5's nasal cannula was exposed, was hang over the side rails in between the urinal, and bag was stored in the oxygen concentrator was dated 12/1/24. On 1/15/25 at 0950 hours, an interview was conducted with the DON. The DON stated nurses are expected to keep the respiratory equipment clean, change the oxygen cannula every week and store in bags to prevent infection. The DON was informed of and acknowledged the above findings.

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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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services for one of 13 sampled residents (Resident 8) to meet the needs of each resident as evidenced by: * The facility failed to ensure the medication was administered as ordered to Resident 8. This failure had the potential for poor health outcome to Resident 8. Findings: Review of facility's P&P titled Medication Orders dated 4/2008 showed the medication orders specify the following: a. Name of medication b. Strength of medication, where indicated c. Dose and dosage form d. Time or frequency of administration e. Route of administration (If facility policies allow, orders are assumed to be PO unless otherwise specified) f. Quantity or duration (length) of therapy. If not specified by prescriber on a new order, the duration is limited by automatic stop order policy, when applicable. g. Diagnosis or indication for use Review of facility's P&P titled Administering Medications revised 4/2019 showed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, right method (route) of administration before giving the medication. Medical record for Resident 8 was initiated on 1/9/25. Resident 8 was admitted on [DATE]. Review of Resident 8's H&P examination dated 7/18/24, showed Resident 8 had the capacity to understand and make decisions. Review of Resident 8's Order Summary dated 1/9/25, showed a physician's order dated 7/12/24, to administer probiotic oral capsule saccharomyces boulardii (a yeast-based probiotic) one capsule by mouth one time a day for supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 0851 hours, an interview was conducted with Resident 8. Resident 8 stated since 12/20/24, she had been receiving acidophilus for probiotic. Resident 8 stated she was not informed of the change in her probiotic order. Resident 8 further stated her current probiotic supplement was not effective and was experiencing changes in her bowel movement. On 1/9/25 at 1414 hours, an interview and a concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 8 had an order for the saccharomyces boulardii probiotic supplement. LVN 3 was asked to show the supply of probiotic supplement he administered to Resident 8. LVN 3 showed the supply bottle labeled acidophilus (a bacteria-based probiotic). LVN 3 verified the acidophilus probiotic was different from Resident 8's order for saccharomyces boulardii probiotic. LVN 3 stated the difference between the saccharomyces boulardii and acidophilus probiotics was the active ingredients. LVN 3 stated Resident 8 had been receiving the acidophilus probiotic supply because it was the facility's current supply. On 1/10/25 at 1108 hours, an interview and a concurrent medical record review was conducted with LVN 8. LVN 8 verified LVN 3 verified Resident 8had an order for the saccharomyces boulardii probiotic. When LVN 8 was asked what type of probiotic supplement he administered to Resident 8, LVN 8 showed the bottle supply for acidophilus. LVN 8 stated he administered the acidophilus probiotic because it was the facility's current supply. On 1/15/25 at 0955 hours, an interview was conducted with the DON. The DON stated she expected the nurses to call the physician to clarify and change the probiotic order to reflect the available supply in the facility. The DON was informed and acknowledged the above findings.