

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2025
NAME OF PROVIDER OR SUPPLIER  Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  141 South Knott Avenue 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2025
NAME OF PROVIDER OR SUPPLIER  Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  141 South Knott Avenue 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of eight sampled residents' (Resident 5) medical record were complete and readily accessible upon request, in accordance with facility's P&amp;P. * The facility was unable to provide Resident 5's medical record, which included the physician's orders, assessments, progress notes, and discharge plan documentation. This failure had resulted in the facility not being able to show Resident 5's discharge planning and teaching was provided to the resident and the resident's family member, to ensure a safe discharge for the resident. Findings: Review of the facility's P&amp;P titled Retention of Medical Records (undated) showed the medical records of discharged residents will be retained for a period of 10 years. Review of the facility's P&amp;P titled Access to Personal and Medical Records (undated) showed the access to the resident's personal and medical records will be provided to the resident within 24 hours (excluding weekends and holidays) of his or her request. The resident may obtain a copy of his or her personal medical record within two business days of an oral or written request. Representatives of the State Long-Term Care Ombudsman may examine a resident's medical, social and administrative records in accordance with the State Law. Review of the facility's P&amp;P titled Transfer or Discharge (undated) showed when the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider:a. The basis for the transfer or discharge;b. That an appropriate notice was provided to the resident and/or legal representative;c. The date and time of the transfer or discharge;d. The new location of the resident;e. The mode of transportation;f. A summary of the resident's overall medical, physical, and mental condition;g. Disposition of personal effects;h. Disposition of medications;i. Others as appropriate or as necessary; andj. The signature of the person recording the data in the medical record . If the basis for the discharge is that the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the resident's physician (or provider) documents information about the resident's condition and the appropriateness of the discharge. Under the Transfer or Discharge Appeals section showed the following:1. Residents have the right to appeal a transfer or discharge through the state agency that handles appeals.2. Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including:a. the name, address, email, and telephone number of the entity which receives such requests;b. information about how to obtain, complete, and submit an appeal form; andc. how to get assistance completing the appeal process. On 9/2/25, CDPH, L&amp;C Program received a complaint from Resident 5's family member, stating the facility discharged the resident too early. Closed medical record review for Resident 5 was initiated on 9/24/25. Resident 5 was admitted to the facility on [DATE], and was discharged on 3/5/16. Review of Resident 5's closed medical record failed to show the documentation regarding the resident's discharge plan and the notification for the notice of discharge. Further review of Resident 5's closed medical record showed the resident's medical record was incomplete. On 9/16/25 at 1626 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated the discharge residents' medical record were sent to an offsite storage company. The Medical Records Director stated the residents' medical record would be retained for 10 years. On 9/24/25 at 0900 hours, an interview and closed medical record review was conducted with the Administrator. The Administrator provided some parts of Resident 5's medical record that was retrieved from the resident's electronic medical record. which included Resident 5's admission record, vital signs, laboratory results report, MDS assessments, and plan of care. On 9/24/25 at 1004 hours, a follow up interview was conducted with the Medical Records Director. The Medical Records Director stated she had received six boxes from the offsite facility storage company, however, Resident 5's medical record was not included in the boxes she received. The Medical Records Director stated she requested four more boxes from the offsite storage company and expected to receive the delivery by today or tomorrow. On 9/25/25 at 0919 hours, a follow up interview was conducted with the Medical Records Director. The Medical Records Director stated she had not received any delivery for the discharged resident's medical record from the offsite storage company. The Medical Records Director stated the log containing the list of the medical record sent to the offsite storage company was incomplete. The Medical Records Director further stated she could not find the log to identify the box number where Resident 5's medical record was stored. On 9/25/25 at 1645 hours, an interview was conducted with the Administrator. The Administrator was informed and</p>		