

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  05/21/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</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 obtain the informed consent prior to administering the new or increased psychotropic medications for two of six final sampled residents (Residents 10 and 30) reviewed for the informed consent.</p> <p>* Resident 30's informed consent was completed after the resident had started the psychotropic medication.</p> <p>* The facility failed to ensure Resident 10's informed consent was obtained prior to administering the quetiapine fumarate (antipsychotic medication) for Resident 10.</p> <p>These failures had the potential for the residents not being fully informed of the medications and the potential effects of the medications.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Psychotropic Medication Used effective June 2021 showed the facility shall verify informed consent prior to the administration of a psychotropic medication.</p> <p>1. Medical record review for Resident 30 was initiated on 5/18/25. Resident 30 was admitted to the facility on [DATE].</p> <p>Review of Resident 30's Order Summary Report showed a physician's order dated 2/7/25, to administer trazadone HCl (an antidepressant medication) 100 mg tablet by mouth at bedtime for depression.</p> <p>Review of Resident 30's Psychotropic Medication Administration Disclosure showed the informed consent was obtained from the resident on 3/5/25.</p> <p>On 5/19/25 at 1416 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 30's trazadone medication was administered to the resident prior to obtaining the informed consent for the use of the medication.</p> <p>2. Medical record review for Resident 10 was initiated on 5/18/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 10 's annual MDS assessment dated [DATE], showed Resident 10 had moderately impaired cognition.</p> <p>(continued on next page)</p>

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  05/21/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 10's Order Summary Report showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- dated 3/10/25, to administer quetiapine fumarate 50 mg one tablet by mouth daily for schizoaffective disorder manifested by inconsolable screaming, and</li> <li>- dated 3/14/25, to administer quetiapine fumarate 100 mg by mouth at bedtime for schizoaffective disorder manifested by inconsolable screaming.</li> </ul> <p>Review of Resident 10's Psychotropic Medication Administration Disclosure dated 3/14/25, showed an informed consent was obtained from Resident 10's family member for the quetiapine fumarate 100 mg at bedtime for schizoaffective disorder. However, further review of Resident 10's medical record failed to show an informed consent was obtained by the physician for the quetiapine fumarate 50 mg daily.</p> <p>Review of Resident 10's MAR for May 2025 showed Resident 10 was administered the following medications:</p> <ul style="list-style-type: none"> <li>- quetiapine fumarate 50 mg one tablet daily from 5/1 to 5/20/25 at 0900 hours, and</li> <li>- quetiapine fumarate 100 mg one tablet at bedtime from 5/1 to 5/19/25 at 2100 hours.</li> </ul> <p>On 5/21/25 at 1111 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON stated for the use of the psychotropic medication, the informed consent would be obtained for the initial physician's order and when the dose was changed. The ADON reviewed Resident 10's medical record and verified the above findings.</p> <p>On 5/21/25 at 1450 hours, a follow-up interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON stated she could not find the informed consent for Resident 10's use of the quetiapine fumarate 50 mg daily.</p> <p>On 5/21/25 at 1500 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.</p>

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  05/21/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the safe self-administration of the medication for one of 21 final sampled residents (Resident 27).</p> <p>* A bottle of artificial tears eye drop (medication to temporarily relieve dry, irritated eyes) was kept at Resident 27's bedside table. Resident 27 was not assessed to ensure the resident was safe to self-administer the medication. This failure had the potential to negatively impact the resident's physiological well-being and the potential for the resident to administer the medications inaccurately.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Self- Administration of Medications undated showed residents have the right to self-administer the medication if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. Upon request of the resident, the IDT assesses each resident's cognitive and physical abilities to determine whether self - administering of medication is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medication is safe and appropriate for the resident:</p> <ul style="list-style-type: none"> <li>- The medication is appropriate for self-administration;</li> <li>- The resident is able to read and understand medication labels;</li> <li>- The resident can follow directions and tell time to know when to take the medication;</li> <li>- The resident comprehends the medications' purpose proper doses timing signs of side effects and one to report these to the staff;</li> <li>- The resident has the physical capacity to open medication bottles remove medication from a container and to ingest and swallow (or otherwise administer) the medication; and</li> <li>- The resident is able to safely and securely store the medication.</li> </ul> <p>On 5/18/25 at 0948 hours, an observation and concurrent interview was conducted with Resident 27. Resident 27 was observed sitting on his bed. A bottle of artificial tears eye drop medication was observed on the bedside table, located at the left side of the resident's bed. Resident 27 stated the medication nurse left the medication at the bedside three days ago. Resident 27 further stated he attempted to administer the medication; however, he was not able to administer the artificial tears eye drop medication.</p> <p>Medical record review for Resident 27 was initiated on 5/18/25. Resident 27 was admitted to the facility on [DATE].</p> <p>Review of Resident 27's H&amp;P examination dated 5/12/25, showed Resident 27 had the capacity to make medical decisions.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 27's Order Summary Report showed a physician's order dated 3/22/24, to administer artificial tears ophthalmic solution one drop in both eyes every 12 hours.</p> <p>Further review of the Resident 27's medical record failed to show if the assessment for the self-administration of the medication was completed for Resident 27.</p> <p>On 5/18/25 at 0950 hours, an observation, interview, and medical record review for Resident 27 was conducted with LVN 1. LVN 1 verified the eye drop medication was observed at Resident 27's bedside and stated the medication should not have been kept at the bedside. LVN 1 reviewed the resident's medical record and verified there was no assessment and physician's order for the self-administration of the medication.</p> <p>On 5/20/25 at 1517 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p>

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  05/21/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the physician was notified timely for one of three residents (Resident 22) reviewed for hospitalizations.</p> <p>* The facility failed to notify the physician or an alternate physician timely to obtain orders for Resident 22's change in condition. Additionally, Resident 22's radiology reports showed severe colonic distention from megacolon or ileus, chronic large bowel obstruction not excluded and mild bibasilar air space disease possible aspiration or developing consolidation. When Resident 22's physician was notified, an order to transfer Resident 22 to an acute care hospital for further evaluation and treatment was documented seven hours after the radiology report was transmitted to the facility. These failures had the potential to delay the medical interventions for Resident 22.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Change in Condition: Notification of dated 8/25/21, showed the facility must immediately inform the resident, consult with the resident's physician and/or NP, and notify, consistent with his/her authority, the Resident Representatives when there is:</p> <ul style="list-style-type: none"> <li>- an accident involving the resident.</li> <li>- a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).</li> <li>- 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); or</li> <li>- a decision to transfer or discharge the resident from the center.</li> </ul> <p>When making notifications of above, the facility must ensure that all pertinent information is available and provided upon request to the physician and/or NP.</p> <p>Medical record review for Resident 22 was initiated on 5/18/25. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>On 5/19/25 at 0927 hours, during the medication administration observation with LVN 1, Resident 22's abdomen was observed distended.</p> <p>Review of Resident 22's plan of care showed a care plan problem dated 5/15/25, addressing Resident 22's dependence on the GT feeding for his nutrition and hydration. The interventions included to monitor/document/report to the physician as needed: aspiration, fever, shortness of breath, tube dislodged, infection at the tube site, abdominal pain, distention, tenderness; and to obtain and monitor laboratory/diagnostic work as ordered and report the results to the physician and follow up as indicated.</p> <p>(continued on next page)</p>

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  05/21/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 22's SBAR Communication Form dated 5/19/25, showed the licensed nurse documented Resident 22 had chest congestion with occasional cough, abdomen distended, bowel sounds present to four quadrants. The physician/NP was notified of change of condition and gave the orders for STAT chest x-ray, KUB, and labs. The SBAR Communication Form showed the physician was notified on 5/19/25 at 1030 hours.</p> <p>Review of Resident 22's Order Summary Report showed an order for a STAT chest x-ray and KUB for Resident 22 on 5/19/25.</p> <p>Review of Resident 22's Progress Notes showed LVN 9's entry dated 5/19/25 at 2337 hours, showing the radiologist was on-site at approximately 2310 hours (more than 12 hours after the documented time of when the physician was notified) to complete (the) imaging, and awaiting results.</p> <p>Review of Resident 22's Radiology Report (of the abdomen) dated 5/19/25, showed Resident 22 had severe colonic distention from megacolon or ileus. Chronic large bowel obstruction was not excluded. The Radiology Report showed the result was signed by the radiologist on 5/19/25 at 2338 hours, and transmitted to the facility on 5/19/25 at 2352 hours.</p> <p>Review of Resident 22's Radiology Report (chest x-ray) dated 5/19/25, showed Resident 22 had mild bibasilar airspace disease, possible aspiration, or developing consolidation. The Radiology Report showed the result was signed by the radiologist on 5/19/25 at 2336 hours, and transmitted to the facility on 5/20/25 at 0007 hours.</p> <p>Review of Resident 22's Progress Notes showed the ADON's entry dated 5/20/25 at 0719 hours (more than seven hours after the abnormal radiology reports were faxed to the facility) regarding the laboratory results, chest x-ray and KUB results were relayed to the physician/NP with the orders for acute care hospitalization for further evaluation and treatment as indicated.</p> <p>On 5/20/25 at 1413 hours, an interview was conducted with LVN 4. LVN 4 stated upon the shift change, LVN 9 (from the night shift) had reported to her that LVN 9 had attempted to call the physician to inform the physician of the results of the chest x-ray and KUB and was awaiting for a call back from the physician. LVN 4 stated LVN 9 did not inform her when she had called the physician.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/20/25 at 1500 hours, an interview and concurrent medical record review for Resident 22 was conducted with the ADON. The ADON verified the above findings. When asked about the delay in the STAT chest x-ray and KUB, the ADON stated the change in condition was initiated by LVN 1 on 5/19/25 at 1030 hours; however, LVN 1 was not able to complete the documentation for the change in condition. When asked if LVN 1 attempted to call the physician again, the ADON stated there was no documentation showing LVN 1 attempted to call the physician again to notify the physician of Resident 22's change in condition. The ADON stated when notifying the physician of a resident's change in condition, if the physician could not be reached, the licensed nurse should re-attempt to call within 30 minutes to one hour. The ADON stated if the licensed nurse was still unable to reach the physician, then then licensed nurse should contact the Medical Director. When asked about the order for the STAT chest x-ray and KUB, the ADON stated on 5/19/25 at around 1800 hours, she followed-up on Resident 22's change in condition and did not see the documentation showing the physician was notified or any orders related to the change in condition. The ADON stated she called the NP to inform of Resident 22's change in condition and obtained the orders and completed the change in condition documentation. The ADON stated for STAT imaging, the results should be uploaded within four hours of the images being taken. The ADON stated LVN 9 should have had access to the imaging results during her shift. The ADON reviewed Resident 22's imaging results and stated LVN 9 should have called the physician to inform the physician of the results and documented the call. The ADON further stated if LVN 9 was unable to reach the physician, she should re-attempt and call the physician after 30 minutes and if still was unable to reach the physician, she should call to inform the Medical Director. The ADON reviewed the progress notes and stated there was no documentation LVN 9 had informed the physician of the imaging results. The ADON stated she came into facility at 0700 hours, and saw the printed imaging results at her desk. The ADON stated she called to notify the physician and received the orders from the NP to transfer Resident 22 to the acute care hospital for evaluation.</p> <p>On 5/21/25 at 0953 hours, a telephone interview was conducted with LVN 9. LVN 9 stated on 5/19/25, she was informed of Resident 22's change in condition by the evening licensed nurse. LVN 9 stated when she started her shift, the radiologist was already at the facility. LVN 9 stated she received the faxed report of the imaging results around midnight. LVN 9 further stated she briefly reviewed the imaging results and called the physician on 5/20/25 at 0045 hours, and left a message. When asked if the physician returned the call, LVN 9 stated no. When asked if LVN 9 attempted to call the physician again, LVN 9 stated she had planned to endorse to the morning licensed nurse to inform the physician of the imaging results.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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 provide reasonable care for the protection of the resident's personal property from loss or theft for one of one final sample resident (Resident 51) reviewed for personal property.</p> <p>* Resident 51's personal belonging was not listed in the inventory form. This failure had the potential for the resident's property to get lost or stolen.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Resident's Personal Property dated 8/25/21, showed the facility to protect the resident right to retain his/her personal belongings and preserve the resident individuality and dignity. All items brought into the facility will be listed on the Inventory of Personal Effects form and kept in the resident clinical chart. Any additional items brought into the facility after admission must be added to this list. The facility to obtain the signatures of the resident or resident's representative and employee with the date.</p> <p>Further review of the P&amp;P showed the facility is not liable for items which have not been requested to be included in the inventory or for items which have been deleted from the inventory.</p> <p>Medical record review for Resident 51 was initiated on 5/18/25. Resident 51 was admitted to the facility on [DATE].</p> <p>Review of Resident 51's Inventory of Personal Effects dated 3/15/23, showed Resident 51 had no personal belongings.</p> <p>Review of Resident 51's MDS assessment dated [DATE], showed Resident 51 had moderate cognitive impairment.</p> <p>On 5/20/25 at 1121 hours, an interview and concurrent medical record review for Resident 51 was conducted with the SSD. The SSD stated Resident 51 recently reported his wallet being lost; however, the facility staff were able find his wallet right away. The SSD further stated she and the facility staff were aware that Resident 51 had a wallet in his possession. The SSD verified the resident's Inventory of the Personal Effects did not show the wallet listed as Resident 51's personal belonging. The SSD stated Resident 51's wallet should be listed in the Inventory of the Personal Effects for Resident 51.</p> <p>On 5/20/25 at 1139 hours, an interview and concurrent medical record review was conducted with LVN 6. When LVN 6 was asked if Resident 51 had any personal belongings, LVN 6 stated Resident 51 had wallet that he held in his hand most of the time. LVN 6 stated she was not sure how long Resident 51 had the wallet with him. LVN 6 verified Resident 51's Inventory of Personal Effects did not show the wallet listed as the resident's personal belonging. LVN 6 stated the wallet should have been listed in the Resident 51's Inventory of Personal Effects, so the facility could safeguard Resident 51's personal belongings.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/20/25 at 1517 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p>

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</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 two of five final sampled residents (Residents 10 and 22) reviewed for unnecessary medications were free from unnecessary psychotropic medications.</p> <p>* The facility failed to ensure Resident 10's orthostatic blood pressure was accurately monitored as ordered by the physician and per the care plan for the use of the psychotropic medications. In addition, the facility failed to implement the nonpharmacological interventions for Resident 10's use of the lorazepam (antianxiety), aripiprazole (antipsychotic), duloxetine (antidepressant), and quetiapine (antipsychotic) medications.</p> <p>* The facility failed to ensure Resident 22's orthostatic blood pressure was accurately monitored as ordered by the physician and per the care plan for the use of the Seroquel (antipsychotic) medication.</p> <p>These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medication.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Psychotropic Medication Use dated 6/2021 showed the psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All residents receiving medications used or treat behaviors should be monitored for:</p> <ul style="list-style-type: none"> <li>a. efficacy</li> <li>b. risks</li> <li>c. benefits</li> <li>d. harm or adverse consequences.</li> </ul> <p>1. Medical record review for Resident 10 was initiated on 5/18/25. Resident 10 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].</p> <p>Review of Resident 10 's annual MDS assessment dated [DATE], showed Resident 10 had moderately impaired cognition.</p> <ul style="list-style-type: none"> <li>a. Review of Resident 10's Order Summary Report dated 5/18/25, showed the following physician's orders:</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 3/10/25, to administer quetiapine fumarate 50 mg one tablet by mouth daily for schizoaffective disorder (a mental illness characterized by symptoms of both schizophrenia (like delusions and hallucinations) and a mood disorder (like depression or mania) manifested by inconsolable screaming,</p> <p>- dated 3/10/25, to monitor Resident 10's orthostatic BP in the lying position, every Monday during the evening shift,</p> <p>- dated 3/10/25, to monitor Resident 10's orthostatic BP in the sitting position, every Monday during the evening shift,</p> <p>- dated 3/11/25, for the use of the quetiapine medication, to monitor the episodes of inconsolable screaming every shift and document the non-drug interventions. To document 1. Removed resident from environment, 2. Redirected by engagement in alternative activity, 3. Listened to resident, attempted to calm, familiarize resident with belongings/surroundings, 4. Toileted resident, 5. Ambulated resident (if able), 6. Provided resident with food/drink, every shift. To document the result every shift, document + for effective or - for ineffective, and</p> <p>- dated 3/14/25, to administer quetiapine fumarate 100 mg by mouth at bedtime for schizoaffective disorder manifested by inconsolable screaming.</p> <p>Review of Resident 10's plan of care showed a care plan problem dated 4/21/24, addressing Resident 10's risk for complications related to the use of the psychotropic medications. The interventions included weekly antipsychotic medication monitoring for the orthostatic BP (lying, sitting standing) and monitoring for the episodes of inconsolable screaming every shift, and to document the non-drug interventions attempted. To document: 1. Removed resident from environment, 2. Redirected by engagement in alternative activity, 3. Listened to resident, attempted to calm, familiarize resident with belongings/surroundings, 4. Toileted resident, 5. Ambulated resident (if able), 6. Provided resident with food/drink</p> <p>Review of resident 10's MAR for May 2025 showed the following orthostatic BP readings:</p> <p>- on 5/5/25, the BP reading was documented as 120/70 mmHg for the lying position, and a check mark documented for the sitting position.</p> <p>- on 5/12/25, the BP reading was documented as 125/70 mmHg for the lying position, and a check mark documented for the sitting position.</p> <p>- on 5/19/25, the BP reading was documented as 125/70 mmHg for the lying position, and a check mark documented for the sitting position.</p> <p>Further review of Resident 10's MAR for May 2025 showed Resident 10 had the episodes of inconsolable screaming as follows:</p> <p>- on 4/4/25, three episodes during the evening and night shifts,</p> <p>- on 4/10/25, five episodes during the evening shift,</p> <p>- on 4/11/25, two episodes during the night shift,</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 4/17/25, two episodes during the night shift, and</p> <p>- on 4/18/25, two episodes during the day shift.</p> <p>However, review of Resident 10's MAR for May 2025 showed the nonpharmacological interventions attempted for the quetiapine medication was documented as NA (not applicable) for the above documented behavioral episodes.</p> <p>b. Review of Resident 10's Order summary Report dated 5/18/25, showed the following physician's orders for the use of the lorazepam medication:</p> <p>- dated 3/29/25, to monitor the episodes of anxiety manifested by physical restlessness every shift; and to document the non-drug interventions attempted. To document: 1. Removed resident from environment, 2. Redirected by engagement in alternative activity, 3. Listened to resident, attempted to calm, familiarize resident with belongings/surroundings, 4. Toileted resident, 5. Ambulated resident (if able), 6. Provided resident with food/drink, every shift. To document the result every shift, document + for effective or - for ineffective, and</p> <p>- dated 5/11/25, to administer lorazepam 1 mg one tablet by mouth every six hours as needed for anxiety for 30 days.</p> <p>Review of Resident 10's MAR for May 2025 showed Resident 10 was administered the lorazepam 1 mg one tablet by mouth every six hours as needed on the following dates and times:</p> <p>- on 5/2/25 at 1016 hours,</p> <p>- on 5/4/25 at 1200 hours,</p> <p>- on 5/9/25 at 0532 hours,</p> <p>- on 5/10/25 at 1424 hours,</p> <p>- on 5/14/25 at 0514 hours,</p> <p>- on 5/16/25 at 0730 hours,</p> <p>- on 5/18/25 at 0836 hours, and</p> <p>- on 5/19/25 at 0410 hours.</p> <p>Further review of Resident 10's MAR for May 2025 showed Resident 10 had the episodes of anxiety manifested by physical restlessness as follows:</p> <p>- on 5/2/25, zero episode was documented during the day shift, and two episodes during the night shift. The nonpharmacological intervention attempted was documented as NA.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 5/4/25, one episode during the day shift, and the nonpharmacological interventions attempted were documented as effective; however, the lorazepam 1 mg was administered to Resident 10 during the shift. Three episodes were documented during the evening and night shifts; however, the nonpharmacological interventions attempted were documented as NA.</p> <p>- on 5/8/25, zero episode was documented during the night shift; however, the lorazepam 1 mg was administered to Resident 10 during the shift.</p> <p>- on 5/10/25, zero episode was documented during the day shift; however, the lorazepam 1 mg was administered to Resident 10 during the shift.</p> <p>- on 5/13/25, zero episode was documented during the night shift; however, the lorazepam 1 mg was administered to Resident 10 during the shift.</p> <p>- on 5/15/25, two episodes were documented on the evening shift; however, the nonpharmacological interventions attempted was documented as 0.</p> <p>- on 5/16/25, zero episode was documented during the day shift; however, the lorazepam 1 mg was administered to Resident 10 during the shift. Two episodes were documented during the evening and night shifts; however, the nonpharmacological interventions attempted were documented as NA.</p> <p>- on 5/17/25, two episodes were documented during the night shift; however, the nonpharmacological interventions attempted was documented as NA.</p> <p>- on 5/18/25, two episodes were documented during the day shift; however, the nonpharmacological interventions attempted was documented as 0. Zero episode was documented during the night shift; however, the lorazepam 1 mg was administered to Resident 10 during the shift.</p> <p>c. Review of Resident 10's Order Summary Report dated 5/18/25, showed the following physicians' orders for the use of the duloxetine medication:</p> <p>- dated 3/11/25, to administer duloxetine delayed release 60 mg one capsule by mouth daily for depression related to major depressive disorder manifested by inconsolable crying.</p> <p>- dated 3/29/25, for the use of the antidepressant medication, to monitor the episodes of depression manifested by inconsolable crying every shift. To document the non-drug interventions attempted and to document: 1. Removed resident from environment, 2. Redirected by engagement in alternative activity, 3. Listened to resident, attempted to calm, familiarize resident with belongings/surroundings, 4. Toileted resident, 5. Ambulated resident (if able), 6. Provided resident with food/drink, every shift. To document the result every shift, document + for effective or - for ineffective.</p> <p>Review of Resident 10's MAR for May 2025 showed Resident 10 had the episodes of depression manifested by inconsolable crying as follows:</p> <p>- on 5/2/25, two episodes during the night shift,</p> <p>- on 5/4/25, three episodes during the evening and night shifts,</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 5/11/25, two episodes during the night shift,</p> <p>- on 5/17/25, two episodes on the night shift, and</p> <p>- on 5/18/25, two episodes during the shift.</p> <p>Further review of Resident 10's MAR for May 2025, showed the nonpharmacological interventions attempted were documented as NA or 0 for the above documented behavioral episodes.</p> <p>d. Review of Resident 10's Order Summary Report dated 5/18/25, showed the following physician's orders for the use of the aripiprazole medication:</p> <p>- dated 3/24/25, to administer aripiprazole 20 mg by mouth at bedtime for schizoaffective disorder manifested by disorganized speech and thinking.</p> <p>- dated 3/24/25, for the use of the aripiprazole antipsychotic medication, to monitor the episodes of disorganized speech and thinking, every shift; and to document the non-drug interventions attempted. To document: 1. Removed resident from environment, 2. Redirected by engagement in alternative activity, 3. Listened to resident, attempted to calm, familiarize resident with belongings/surroundings, 4. Toileted resident, 5. Ambulated resident (if able), 6. Provided resident with food/drink, every shift.</p> <p>Review of Resident 10's MAR for May 2025 showed the following documentation for the monitoring of Resident 10's episodes of disorganized speech and thinking:</p> <p>- on 5/1, 5/2, from 5/4 to 5/6, 5/8, from 5/10 to 5/14, and from 5/16 to 5/18/25, during the evening shift the licensed nurses documented YES for the observed behavior. However, further review of Resident 10's MAR for May 2025 failed to show the nonpharmacological interventions attempted for the above documented behavioral episodes, or the number of episodes observed during those shifts.</p> <p>On 5/20/25 at 1014 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 5. LVN 5 stated for the residents taking the psychotropic medications, the residents would be monitored for the manifested behaviors and potential side effects of the psychotropic medications. LVN 5 stated if the manifested behaviors were observed, the nonpharmacological interventions should be implemented and documented and should not be documented as NA or 0 (zero). LVN 5 reviewed Resident 10's medical record and verified the above findings.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 0831 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON stated the residents on psychotropic medications were monitored for manifested behaviors related to the use of the psychotropic medications. The ADON stated if the behaviors were observed, the licensed nurses should implement the nonpharmacological interventions and document the nonpharmacological interventions implemented and the effectiveness of the interventions. The ADON stated if the nonpharmacological interventions implemented were not effective, then the licensed nurse should give the PRN psychotropic medication; however, if the nonpharmacological interventions implemented were effective, the pharmacological interventions would not be needed. The ADON stated if the nonpharmacological intervention was documented as effective, then the PRN medication should not be administered. The ADON further stated if the licensed nurse documented the behavior was observed during the shift, there should be a documentation of the nonpharmacological interventions implemented and its effectiveness. The ADON reviewed Resident 10's medical record and verified the above findings. Additionally, the ADON verified the orthostatic BP for the sitting position was not documented anywhere in Resident 10's MAR or in the progress notes.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p> <p>2. Medical record review for Resident 22 was initiated on 5/18/25. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 22's MDS assessment dated [DATE], showed Resident 22 had moderately impaired cognition.</p> <p>Review of Resident 22's Order Summary Report showed the following physician's orders dated 5/13/25:</p> <ul style="list-style-type: none"> <li>- for use of the antipsychotic medication, to monitor Resident 22's orthostatic BP while lying every week on Saturday, during the day shift; and to notify the physician of the potential orthostatic hypotension indicated by a drop of 20 mmHg in the systolic BP, or a drop of 10 units mmHg in the diastolic BP,</li> <li>- for use of the antipsychotic medication, to monitor Resident 22's orthostatic BP while sitting every week on Saturday, during the day shift; and to notify the physician of the potential orthostatic hypotension indicated by a drop of 20 mmHg in the systolic BP, or a drop of 10 units mmHg in the diastolic BP, and</li> <li>- to administer quetiapine fumarate (antipsychotic medication) 150 mg one tablet via GT at bedtime for psychosis (a condition where a person has difficulty distinguishing between what is real and what is not) manifested by talking to an imaginary person.</li> </ul> <p>Review of Resident 22's plan of care showed a care plan problem dated 5/15/25, addressing Resident 22's risk for complications related to the use of the psychotropic drugs. The interventions included to monitor the orthostatic BP while lying/sitting and to notify the physician for potential orthostatic hypotension indicated by a drop of 20 mmHg in the systolic BP, or a drop of 10 units mmHg in the diastolic BP.</p> <p>Review of Resident 22's MARs for April and May 2025 showed the following documentation:</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- on 4/12/25, the BP readings were 124/65 mmHg for the lying, sitting, and standing position,</li> <li>- on 4/19/25, the BP readings were 129/89 mmHg for the lying, sitting, and standing position,</li> <li>- on 4/26/25, the BP readings were 134/82 mmHg for the lying, sitting, and standing position, and</li> <li>- on 5/17/25, the BP readings were 145/70 mmHg for the lying and sitting position.</li> </ul> <p>On 5/20/25 at 0804 hours, an interview and concurrent medical record review for Resident 22 was conducted with the ADON. The ADON stated the residents on psychotropic medications were being monitored for side effects, including orthostatic hypotension. The ADON stated the monitoring for the orthostatic hypotension was done weekly by obtaining the resident's BP reading in different positions, and comparing the BP readings in the different positions to determine if there was a drop in the BP, which would indicate orthostatic hypotension. The ADON reviewed Resident 22's MARs for April and May 2025 and verified the above findings. The ADON stated the BP readings should not be the same for the different positions.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>

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  05/21/2025
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</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 provide the notice of discharge and discharge summary documentation for one of three sampled residents (Resident 90) reviewed for closed records. This failure had the potential for Resident 90 to have an inappropriate discharge.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Transfer or Discharge revised 4/2025 showed when a resident is discharged from the facility, the facility will provide information for the basis of discharge and appropriate notice of discharge to the resident and/or their representative. The information provided is documented in the resident's medical record.</p> <p>Medical record review for Resident 90 was initiated on 5/19/25. Resident 90 was admitted to the facility on [DATE].</p> <p>Review of Resident 90's H&amp;P examination dated 12/30/24, showed Resident 90 had the capacity to understand and make decisions.</p> <p>Review of Resident 90's Physician Order Summary showed a physician's order dated 2/18/25, to discharge Resident 90 to an assisted living facility on 2/21/25.</p> <p>Review of Resident 90's Discharge Plan Documentation v2 dated 2/19/25 at 1123 hours, showed Resident 90 was transferred to the assisted living facility.</p> <p>Review of Resident 90's medical record failed to show if the notice of discharge and discharge summary were provided to Resident 90 when the resident was discharged to the assisted living facility on 2/19/25.</p> <p>On 5/19/25 at 1441 hours, an interview and concurrent medical record review for Resident 90 was conducted with the ADON. The ADON verified Resident 90 was discharged to the assisted living facility on 2/19/25. The ADON was not able to show documented evidence Resident 90 was provided with the written notice of discharge and discharge summary in the resident's medical record. The ADON verified the findings and stated the notice of discharge should be signed by the resident or resident's representative.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/20/25 at 0835 hours, an interview and concurrent medical record review for Resident 90 was conducted with the SSD. The SSD stated each resident was provided with the discharge summary and notice of transfer/discharge which was signed by the resident prior to leaving the facility, and the notice was sent to the Ombudsman. The SSD stated the facility's discharge process included a transfer/discharge packet for the residents who were transferred or discharged to either an acute care hospital, another facility, or at home. The notice of transfer/discharge and discharge summary would be included in each packet. The documents should be completed, a copy provided to the resident, and documented in the resident's medical record. The SSD was not able to show documented evidence Resident 90 was provided with the written notice of the discharge and discharge summary in the resident's medical record. The SSD stated Resident 90 should have the notice of the discharge and discharge summary completed prior to the discharge and documented in the resident's medical record.</p> <p>On 5/21/25 at 1123 hours, an interview was conducted with the DSD and Administrator. The DSD and Administrator were informed and acknowledged the above findings for Resident 90.</p>		

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  05/21/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</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 the PASARR was accurate and updated for one of four final sampled residents reviewed for PASARR (Resident 27). Resident 27 had serious mental illness on admission and had developed the new serious mental illness diagnoses after the initial admission to the facility. This failure had the potential for Resident 27 to be inappropriately placed in the facility and not receive the treatment and services to meet the resident's needs.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled PASARR Completion Policy dated 9/30/24, showed the center will make sure that all admission have the appropriate PASARR Completed. Further review of the P&amp;P showed the facility will follow the state specific guidelines for completion.</p> <p>Medical record review for Resident 27 was initiated on 5/18/25. Resident 27 was admitted to the facility on [DATE].</p> <p>Review of the form titled admission Record dated 5/20/25, showed Resident 27 had the following diagnoses with the onset date:</p> <ul style="list-style-type: none"> <li>- anxiety disorder, onset date of 3/15/17;</li> <li>- major depressive disorder, onset date of 6/9/18; and</li> <li>- bipolar disorder, onset date of 2/11/21.</li> </ul> <p>Review of Resident 27's PASARR Level I Screening dated 3/15/17, showed Resident 27 had no serious mental illness.</p> <p>Further review of the medical record for Resident 27 did not show if PASARR screening was completed when the resident had a new diagnosis of bipolar disorder and major depressive disorder.</p> <p>On 5/20/25 at 0923 hours, an interview and concurrent medical record review for Resident 27 was conducted with the ADON. The ADON stated she was responsible to make sure the PASARR completed by the acute care hospital was done accurately, and the PASARR completed was referred accordingly for the residents who were diagnosed with severe mental illness after the admission to the facility. The ADON verified the above diagnosis of severe mental illness for Resident 27. The ADON verified the PASARR Level I Screening dated 3/15/17, showed Resident 27 had no serious mental illness. The ADON stated anxiety disorder was a severe mental illness and the facility should have coded PASARR Level I Screening dated 3/15/17, accurately. The ADON stated Resident 27 was diagnosed with bipolar disorder and major depressive disorder after the initial admission to the facility. The ADON further stated the facility should have initiated the PASARR screening and referred accordingly after Resident 27 was diagnosed with bipolar disorder and major depressive disorder.</p>		

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  05/21/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 3. Medical record review for Resident 42 was initiated on 5/18/25. Resident 42 was admitted to the facility on [DATE].</p> <p>Review of Resident 42's care plan titled At Risk for Falls initiated 10/25/24, showed Resident 42 was at risk for falls due to cognitive loss and lack of safety awareness. Resident 42's care plan interventions included the implementation of fall (floor) mats.</p> <p>On 5/19/25 at 0853 hours, an observation of Resident 42 was conducted. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place.</p> <p>On 5/19/25 at 1024 hours, an observation of Resident 42 was conducted. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place.</p> <p>On 5/19/25 at 1040 hours, an observation of Resident 42 and concurrent interview was conducted with the DSD. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place. The DSD verified the findings and stated she would implement another floor mat in accordance with Resident 42's fall risk care plan.</p> <p>Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure a comprehensive care plan was developed for two of 21 final sampled residents (Residents 9 and 19) and failed to implement the care plan for one nonsampled resident (Resident 42).</p> <p>* The facility failed to to develop a comprehensive person-centered care plan to address Resident 9's use of Namenda (medication used for cognitive loss).</p> <p>* The facility failed to develop a comprehensive person-centered care plan to address Resident 19's depressive signs and symptoms.</p> <p>* The facility failed to implement Resident 42's fall risk care plan for the use of the bilateral floor mats.</p> <p>These failures had the potential risk of not providing appropriate, consistent, and individualized care to the residents.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Care Plan Comprehensive dated 8/25/21, showed the facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Medical record review for Resident 9 was initiated on 5/18/25. Resident 9 was admitted on [DATE], and readmitted to the facility on [DATE].</p> <p>Review of the Resident 9's physician's order dated 12/11/24, showed Aricept (medication used for dementia) tablet 5 mg one tablet by mouth at bedtime for dementia related to unspecified dementia, moderate, with mood disturbance. Further review of Resident 9's physician's orders showed an order dated 12/11/24, for Namenda (medication used for dementia) tablet 5 mg one tablet by mouth two times a day for dementia related to unspecified dementia, moderate, with mood disturbance.</p> <p>Review of Resident 9's plan of care failed to show documented evidence a care plan was developed to address the use of the Aricept and Namenda medications for dementia as ordered by the physician.</p> <p>On 5/21/25 at 1240 hours, an interview and concurrent medical record review for Resident 9 was conducted with the ADON. The ADON was asked about the facility's process regarding the medications prescribed by the physicians. The ADON stated for every physician's order, there should be a care plan. The ADON verified Resident 9's care plan for the use of the Aricept and Namenda medications ordered by the physician was missed and should have been initiated.</p> <p>2. Medical record review for Resident 19 was initiated on 5/18/25. Resident 19 was admitted to the facility on [DATE].</p> <p>Review of Resident 19's physician's order dated 2/1/24, showed an order for psychologist evaluation and treatment as needed. Further review of Resident 19's physician's orders showed an order dated 2/29/24, for psychology consult and treatment if indicated.</p> <p>Review of Resident 19's psychologist's evaluation dated 2/19/24, showed Resident 19 reported in the last week having periods of low mood, low motivation, and increased fatigue. The Treatment Plan Summary/Recommendations/Collateral Information/Comments showed Resident 19 would work on focusing on self-care during the week. Future sessions would build on insight and utilize motivational interviewing.</p> <p>Review of the psychologist's evaluation dated 3/4/24, showed Resident 19 exhibited depressive signs and symptoms and was noted this past week having moments of low energy, isolative behaviors, and fatigue. The Treatment Plan Summary/Recommendations showed Resident 19 would work on spending at least one day outside. Future sessions would build on insight and utilize motivational interviewing.</p> <p>On 5/21/25 at 1240 hours, an interview and concurrent medical record review for Resident 19 was conducted with the ADON. The ADON was asked for a care plan problem to address Resident 19's reported depressive signs and symptoms. The ADON verified the care plan problem to address the depressive signs and symptoms was missed.</p>		

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  05/21/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and medical record review, the facility failed to ensure a physician's order for the orthostatic blood pressure monitoring while standing was clarified for one of 21 final sampled residents (Resident 31). This failure placed the resident at risk of receiving services not appropriate for his functional level.</p> <p>Findings:</p> <p>Review of Resident 31's Order Summary Report showed a physician's order dated 2/21/25, to monitor the resident's BP for orthostatic hypotension weekly while lying, sitting, and standing.</p> <p>Review of Resident 31's MAR for May 2025 showed the weekly monitoring of the resident's BP while standing were not completed.</p> <p>On 5/19/25 at 1402 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated Resident 31 was not able to stand without two facility staff supporting the resident, and checking the resident's BP while standing was not appropriate for the resident. The ADON stated the physician's order should have been clarified with the physician.</p>

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  05/21/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure two nonsampled residents (Residents 25 and 42) remained free from accident hazards.</p> <p>* The facility failed to ensure the bilateral floor mats were implemented in accordance with the physician's order for Resident 42.</p> <p>* The facility failed to ensure Resident 25 had a physician's order prior to going out on pass.</p> <p>These failures had the potential to place the residents at risk for injury.</p> <p>Findings:</p> <p>1. Medical record review for Resident 42 was initiated on 5/18/25. Resident 42 was admitted to the facility on [DATE].</p> <p>Review of Resident 42's physician's orders showed an order dated 10/25/24, for the use of the bilateral floor mats.</p> <p>Review of Resident 42's care plan titled At Risk for Falls initiated 10/25/24, showed Resident 42 was at risk for falls due to cognitive loss and lack of safety awareness.</p> <p>On 5/19/25 at 0853 hours, an observation of Resident 42 was conducted. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place.</p> <p>On 5/19/25 at 1024 hours, an observation of Resident 42 was conducted. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place.</p> <p>On 5/19/25 at 1040 hours, an observation of Resident 42 and concurrent interview was conducted with the DSD. Resident 42 was observed lying in her bed. Resident 42's bed was observed with only one floor mat in place adjacent to Resident 42's bed. The opposite side of Resident 42's bed was observed without a floor mat in place. The DSD verified the findings and stated she would implement another floor mat in accordance with the physician's order.</p> <p>Cross reference to F656, example #3.</p> <p>2. Review of the facility's P&amp;P titled Out on Pass Policy revised 4/11/25, showed the physician will determine if the resident may participate in activities outside the facility and will write a physician's order.</p> <p>Medical record review for Resident 25 was initiated on 5/20/25. Resident 25 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 25's Order Summary Report for 5/2025 failed to show a physician's order for the resident to leave the facility on a therapeutic pass.</p> <p>Review of Resident 25's Care Plan Report failed to show the resident could safely go out on pass without supervision.</p> <p>Review of the facility's Release for Temporary Absence form for Resident 25 showed the resident left the facility out on pass for 30 days in January, 24 days in February, 31 days in March, 30 days in April, and 20 days in May 2025.</p> <p>On 5/20/25 at 1226 hours, Resident 25 was observed in front of a dental office next to the facility.</p> <p>On 5/20/25 at 1403 hours, an interview was conducted with Resident 25. Resident 25 stated he went out on pass and was returning from his pass when he was observed at 1226 hours.</p> <p>On 5/20/25 at 1441 hours, an interview and concurrent medical record review and facility record review was conducted with the ADON. The ADON stated for the residents who went out on pass, they should have a physician's order and sign themselves out on the logbook. The ADON stated Resident 25 frequently went out on pass to visit a friend at a nearby facility, and provided the Release for Temporary Absence forms for Resident 25 from the log book. The ADON verified the resident had no physician's order or a care plan for the resident to go out on pass.</p>

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  05/21/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 3. Review of the facility's P&amp;P titled Oxygen Administration dated 1/31/23, showed to verify that there is a physician order for this procedure. Further review of the P&amp;P showed to review the physician orders or facility protocol for oxygen administration.</p> <p>On 5/18/25 at 1000 hours, Resident 493 was observed lying in his bed. The oxygen concentrator was observed set at three LPM. The nasal cannula was observed connected to the oxygen concentrator; however, the nasal cannula was observed on Resident 493's forehead and not in the resident's nose.</p> <p>Medical record review for Resident 493 was initiated on 5/18/25. Resident 493 was admitted to the facility on [DATE].</p> <p>Review of Resident 493's H&amp;P examination dated 2/10/25, showed Resident 493 had no capacity to understand and make decisions.</p> <p>Review of Resident 493's Order Summary Report showed the following physician's orders dated 5/1/25:</p> <ul style="list-style-type: none"> <li>- to administer oxygen at two LPM via nasal cannula as needed for short of breath, and may titrate to keep oxygen saturation level 90% and above; and,</li> <li>- to monitor pulse oximetry every shift to keep oxygen saturation level greater than or equal to 90% for shortness of breath for oxygen use.</li> </ul> <p>Review of Resident 493's MAR for 5/2025 did not show if the oxygen was being administered. In addition, the MAR had no documented evidence if Resident 493 had an oxygen saturation level less than 90 % requiring the administration of oxygen.</p> <p>Further Review of Resident 493 medical record failed to show if Resident 493 had shortness of breath requiring oxygen administration.</p> <p>On 5/18/25 at 1015 hours, a concurrent observation, interview, and medical record review for Resident 493 was conducted with the LVN 7. LVN 7 stated the PRN administration of the oxygen required the documentation and reason as to why the PRN oxygen was being administered. LVN 7 stated the administration of the oxygen was documented in the MAR. LVN 7 verified the above observation. LVN 7 stated Resident 493 had been receiving continuous oxygen administration. LVN 7 was observed putting the nasal cannula into Resident 493 's nose. LVN 7 then reviewed the records and verified the above physician's order for the oxygen for Resident 493. LVN 7 stated he was not able to find the documentation of the PRN administration of the oxygen. LVN 7 further stated he was not able to find documented evidence Resident 493 was having shortness of breath or if the oxygen saturation level was below 90% requiring the oxygen administration. LVN 7 stated the administration of the oxygen should have been documented in the MAR, and the reason for PRN administration of the oxygen should have been documented in the medical record for Resident 493.</p> <p>On 5/20/25 at 1517 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and medical record review, the facility failed to ensure two of two final sampled residents (Residents 61 and 493) and one nonsampled resident (Resident 59) reviewed for respiratory care were provided the appropriate respiratory care.</p> <ul style="list-style-type: none"> <li>* The facility failed to ensure Resident 59's oxygen order was carried out as ordered by the physician.</li> <li>* The facility failed to ensure Resident 61's oxygen order was carried out as ordered by the physician.</li> <li>* The facility failed to ensure Resident 493 received oxygen administration as ordered by the physician.</li> </ul> <p>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Oxygen Administration (undated) showed the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&amp;P further showed to verify that there is a physician's order for this procedure and review the physician's orders or facility protocol for oxygen administration.</p> <p>1. Medical record review for Resident 59 was initiated on 5/18/25. Resident 59 was admitted to the facility on [DATE].</p> <p>Review of Resident 59's H&amp;P examination dated 1/13/25, showed Resident 59 had fluctuating capacity to understand and make decisions.</p> <p>On 5/18/25 at 0929 hours, an observation, interview, and concurrent medical record review was conducted with LVN 5. Resident 59 was observed at six LPM of oxygen via nasal cannula. LVN 5 verified the findings. LVN 5 reviewed Resident 59's medical record and verified Resident 59 had a physician's order for continuous oxygen at two LPM via nasal cannula. LVN 5 stated the oxygen administered should match the physician's order.</p> <p>2. Medical record review for Resident 61 was initiated on 5/18/25. Resident 61 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 61's H&amp;P examination dated 4/24/25, showed the resident had the capacity to understand and make decisions.</p> <p>On 5/18/25 at 0826 hours, during an initial tour of the facility, Resident 61 was observed receiveing oxygen five LPM via nasal cannula.</p> <p>On 5/18/25 at 0838 hours, an observation, interview, and concurrent medical record review was conducted with the DSD. The DSD reviewed Resident 61's medical record and verified Resident 61 had a physician's order for continuous oxygen at three LPM via nasal cannula. The DSD verified the findings and stated the physician's order for the oxygen should match what being administered to the resident.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and verified the above findings.</p>

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  05/21/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Medical record review for Resident 10 was initiated on 5/18/25. Resident 10 was readmitted to the facility on [DATE].</p> <p>a. Review of Resident 10's Order Summary Report showed a physician's order dated 3/10/25, to monitor the resident's pain every shift.</p> <p>Review of Resident 10's MAR for 5/2025 failed to show the resident's pain level was monitored and documented every shift.</p> <p>Review of Resident 10's facility Progress Notes failed to show the resident's pain was assessed for 5/2025.</p> <p>Review of Resident 10's Weight and Vitals Summary for 5/2025 showed the following:</p> <ul style="list-style-type: none"> <li>- On 5/3/25, the resident's pain level was zero for the 0700 - 1500 hours shift.</li> <li>- On 5/5/25, the resident's pain level was zero at 1500 hours.</li> <li>- On 5/9/25, the resident's pain level was zero for the 0700 - 1500 hours shift.</li> <li>- On 5/10/25, the resident's pain level was four for the 0700 - 1500 hours shift.</li> <li>- On 5/16/25, the resident's pain level was zero for the 1500 - 2300 hours shift.</li> </ul> <p>On 5/19/25 at 1422 hours, an interview and concurrent record review for Resident 10 was conducted with the ADON. The ADON verified Resident 10's pain level was not monitored and documented every shift.</p> <p>b. Review of Resident 10's Order Summary Report showed a physician's order dated 3/11/25, for acetaminophen (a pain reliever) two 325 mg tablets by mouth every four hours as needed for moderate pain (5-7 on the pain scale).</p> <p>Review of Resident 10's MAR for 5/2025 showed on 5/10/25 at 1158 hours, two acetaminophen 325 mg tablets were administered for a pain level of 4.</p> <p>On 5/19/25 at 1422 hours, an interview and concurrent record review for Resident 10 was conducted with the ADON. The ADON verified Resident 10's MAR showed the resident received two 325 mg tablets of acetaminophen for a pain level of 4, which was below the ordered pain levels of 5-7.</p> <p>3. Medical record review for Resident 30 was initiated on 5/18/25. Resident 30 was admitted to the facility on [DATE].</p> <p>Review of Resident 30's Order Summary Report showed a physician's order dated 1/15/25, to monitor the resident's pain every shift.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 30's MAR for 5/2025 failed to show the resident's pain level was monitored and documented every shift.</p> <p>Review of Resident 30's facility Progress Notes failed to show the resident's pain was assessed for 5/2025.</p> <p>Review of Resident 30's Weight and Vitals Summary for May 2025 showed the following:</p> <ul style="list-style-type: none"> <li>- On 5/4, 5/5, 5/6, 5/7, 5/8, 5/10, 5/11, 5/12, 5/13, 5/16, and 5/18/25, the resident's pain level was zero for the 0700 - 1500 hours shift.</li> <li>- On 5/4, 5/7, 5/8, 5/9, 5/14, 5/15, and 5/16/25, the resident's pain level was zero for the 1500 - 2300 hours shift.</li> </ul> <p>On 5/19/25 at 1416 hours, an interview and concurrent record review for Resident 30 was conducted with the ADON. The ADON verified Resident 30's pain level was not documented every shift, and should have been.</p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to provide the appropriate pain management for three of three final sampled residents (Residents 10, 30, and 45) reviewed for pain management.</p> <ul style="list-style-type: none"> <li>* The facility failed to accurately document the monitoring of pain for Resident 45 and administer the pain medications according to the physician's order. In addition, the facility failed to ensure the non-pharmacological interventions for pain were provided to Resident 45 prior to the administration of the pain medications as per the physician's order.</li> <li>* Resident 10 was administered pain medication outside of the ordered pain level parameters.</li> <li>* Residents 10 and 30's pain level was not monitored and documented as ordered.</li> </ul> <p>These failures had the potential to put Residents 10, 30, and 45 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Pain Assessment and Management revised 3/2020 showed non-pharmacological interventions may be appropriate alone or in conjunction with medications. Pharmacological interventions may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident (e.g., drowsiness, increased risk of falling; loss of appetite). Implement the medication regime as ordered, carefully documenting the results of the interventions.</p> <p>1.a. Medical record review for Resident 45 was initiated on 5/18/25. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 45's MDS assessment dated [DATE], showed Resident 45 was cognitively intact.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 45's Order Summary Report dated 5/20/25, showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- dated 8/6/24, to monitor Resident 45's pain and document the pain level using the pain rating scale as follows: 1 to 4 = mild pain, 5 to 7 = moderate pain, and 8 to 10 = severe pain.</li> <li>- dated 8/6/24, to document the non-pharmacological intervention(s) as needed. To document: A. Heat, B. Repositioning, C. Relaxation breathing, D. Food/Fluid, E. Massage, F. Exercise, G. Immobilization of joint, H. Other: write in progress notes. Document results of nonpharmacological interventions (-) ineffective or (+) effective,</li> <li>- dated 8/7/24, to administer acetaminophen (analgesic medication) 325 mg one tablet by mouth every four hours as needed for mild pain, pain levels of 1 to 4, do not exceed more than three grams in 24 hours from all sources,</li> <li>- dated 8/7/24, to administer acetaminophen 325 mg two tablets by mouth every four hours as needed for moderate pain, pain levels of 5 to 7, do not exceed three grams of acetaminophen in a day from all other sources, and</li> <li>- dated 8/7/24, to administer hydrocodone-acetaminophen (narcotic opioid medication) 5-325 mg one tablet by mouth every eight hours as needed for severe pain, pain levels of 8 to 10, not to exceed three grams of acetaminophen in 24 hours from all other sources.</li> </ul> <p>Review of Resident 45's plan of care showed a care plan problem dated 6/10/24, addressing Resident 45's risk for alterations in comfort. The interventions included to administer hydrocodone-acetaminophen as ordered, utilize the pain scale, and medicate as ordered for pain and monitor for effectiveness.</p> <p>Review of Resident 45's MAR for 5/2025 showed Resident 45 was administered the acetaminophen 325 mg two tablets by mouth every four hours as needed for moderate pain (pain levels of 5 to 7) on the following dates and times when the resident's pain level was not within the pain levels of 5 to 7 as ordered by the physician:</p> <ul style="list-style-type: none"> <li>- On 5/10/25 at 2000 hours, for a pain level of 4.</li> <li>- On 5/16/25 at 2100 hours, for a pain level of 4.</li> </ul> <p>Further review of Resident 45's MAR for 5/2025 showed Resident 45 was administered the hydrocodone-acetaminophen 5-325 mg medication one tablet by mouth every eight hours as needed for severe pain (pain levels of 8 to 10) on the following dates and times when the resident's pain level was not within the pain levels of 8 to 10 as ordered by the physician:</p> <ul style="list-style-type: none"> <li>- On 5/3/25 at 1700 hours, for a pain level of 6.</li> <li>- On 5/4/25 at 1600 hours, for a pain level of 7.</li> <li>- On 5/5/25 at 1600 hours, for a pain level of 6.</li> </ul> <p>(continued on next page)</p>

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  05/21/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 5/9/25 at 1600 hours, for a pain level of 7.</li> <li>- On 5/11/25 at 1530 hours, for a pain level of 7.</li> <li>- On 5/16/25 at 0100 hours, for a pain level of 7.</li> </ul> <p>b. Review of Resident 45's MAR from 5/2025 showed Resident 45 was administered the following medications on the following dates, times, and pain levels:</p> <p>Resident 45 was administered the acetaminophen medication 325 mg one tablet by mouth every four hours as needed for mild pain (pain levels of 1 to 4):</p> <ul style="list-style-type: none"> <li>- On 5/3/25 at 2000 hours, for a pain level of 3.</li> <li>- On 5/4/25 at 2000 hours, for a pain level of 4.</li> </ul> <p>Resident 45 was administered the acetaminophen 325 mg two tablets by mouth every four hours as needed for moderate pain (pain levels of 5 to 7):</p> <ul style="list-style-type: none"> <li>- On 5/10/25 at 2000 hours, for a pain level of 4.</li> <li>- On 5/16/25 at 2100 hours, for a pain level of 4.</li> </ul> <p>Resident 45 was administered the hydrocodone-acetaminophen 5-325 mg medication one tablet by mouth every eight hours as needed for severe pain (pain levels of 8 to 10):</p> <ul style="list-style-type: none"> <li>- On 5/10/25 at 0300 hours, for a pain level of 8.</li> <li>- On 5/13/25 at 1812 hours, for a pain level of 10.</li> <li>- On 5/18/25 at 0210 hours, for a pain level of 8.</li> <li>- On 5/19/25 at 0047 hours, for a pain level of 8.</li> <li>- On 5/19/25 at 2000 hours, for a pain level of 9.</li> </ul> <p>However, review of Resident 45's MAR for May 2025 for the monitoring of Resident 45's pain level every shift showed the licensed nurses documented Resident 45's pain level was assessed as 0 for no pain for the following dates and shifts:</p> <ul style="list-style-type: none"> <li>- On 5/3/25, for the evening shift;</li> <li>- On 5/4/25, for the evening shift;</li> <li>- On 5/5/25, for the evening shift;</li> <li>- On 5/9/25, for the evening and night shifts;</li> </ul> <p>(continued on next page)</p>

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  05/21/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 5/10/25, for the evening shift;</li> <li>- On 5/11/25; for the evening shift;</li> <li>- On 5/13/25; for the evening shift;</li> <li>- On 5/15/25, for the night shift;</li> <li>- On 5/16/25; for the evening shift;</li> <li>- On 5/17/25, for the night shift;</li> <li>- On 5/18/25, for the night shift; and</li> <li>- On 5/19/25, for the evening shift.</li> </ul> <p>Additionally, further review of Resident 45's [DATE]/2025 failed to show the documentation of the nonpharmacological pain interventions attempted prior to the administration of the acetaminophen and hydrocodone-acetaminophen pain medications for the above dates and times.</p> <p>On 5/20/25 at 1026 hours, an interview and concurrent medical record review for Resident 45 was conducted with LVN 4. LVN 4 stated the nonpharmacological pain interventions should be implemented and documented prior to the administration of pain medications. LVN 4 further stated the pain medications should be administered as ordered by the physician and within the ordered pain parameters. LVN 4 reviewed Resident 45's medical record and verified the above findings.</p> <p>On 5/21/25 at 0845 hours, an interview and concurrent medical record review for Resident 45 was conducted with the ADON. The ADON stated when pain was reported, the licensed nurse was expected to provide the nonpharmacological interventions for pain and evaluate the effectiveness. The ADON stated if the nonpharmacological interventions were effective, then the pain medication would not be needed; but if the nonpharmacological interventions were not effective, then the licensed nurse should administer the pain medication as ordered by the physician and within the ordered parameters. The ADON further stated the resident's pain was monitored and documented by the licensed nurses each shift and should be documented at the end of the shift to accurately reflect the resident's pain during the shift. The ADON reviewed Resident 45's medical record and verified the above findings.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, facility document review, medical record review, and facility P&amp;P review, the facility failed to ensure the ongoing assessment before, during, and after dialysis treatments for two of two final sampled residents (Residents 45 and 61) reviewed for dialysis was conducted as evidence by:</p> <p>* The facility failed to ensure Resident 45's Hemodialysis Communication Records were complete, and ensure accurate documentation for the monitoring for Resident 45's fluid restriction. In addition, the facility failed to ensure Resident 45 was administered the blood pressure medications after dialysis as per the physician's orders.</p> <p>* The facility failed to ensure Resident 61's Hemodialysis Communication Records were complete and accurate.</p> <p>These failures had the potential of not identifying negative outcomes for dialysis residents.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Dialysis Care dated 8/2021 showed for fluid restrictions dialysis residents are given fluid based on the fluid restriction as ordered by the physician. The nursing and dietary staff will carefully organize the division and distribution of fluids. Medications will be administered prior to and after dialysis, as ordered by the physician. The P&amp;P further showed the nursing staff, dialysis provider staff, and the attending physician staff will collaborate on a regular basis concerning the resident's care as follows:</p> <p>i. Nursing staff will communicate the following information in writing to the dialysis staff: The resident's current vital signs.</p> <p>ii. The dialysis provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required.</p> <p>Moreover, the P&amp;P further showed the nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The provider's dialysis nurse will be responsible for the documentation of dialysis treatment and the documentation will be maintained in the resident's medical record.</p> <p>1. Medical record review for Resident 61 was initiated on 5/18/25. Resident 61 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 61's H&amp;P examination dated 4/24/25, showed the resident had the capacity to understand and make decisions.</p> <p>Review of Resident 61's Order Summary Report for 5/2025 showed the following physician's orders:</p> <p>- dated 4/24/25, for hemodialysis access site monitoring left upper chest dialysis Catheter (site dressing changes at dialysis center and as needed) every shift.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 4/24/25, for hemodialysis access site monitoring left forearm AV fistula every shift for monitoring access site for bruit and thrill.</p> <p>- dated 5/1/25, for access ready for use to certify that the physician is giving orders to start using the resident's left arm fistula on 5/12/25.</p> <p>- dated 5/2/25, for hemodialysis scheduled on Saturdays.</p> <p>- dated 5/24/25, for hemodialysis scheduled Mondays, Wednesdays, and Fridays.</p> <p>Review of the facility's documentation titled Dialysis Center A Access -Ready for Use showed the vascular surgeon approved the use of Resident 61's left arm fistula as of 5/12/25.</p> <p>Review of Resident 61's Hemodialysis Communication Record showed the following missing and inaccurate documentation:</p> <p>- the post-hemodialysis treatment dated 5/7/25, failed to show documentation of the type site, drainage, and pain</p> <p>- the post-hemodialysis treatment dated 5/9/25, failed to show documentation of the type site, swelling, drainage, pain, and if there were new orders from dialysis center.</p> <p>- the post-hemodialysis treatment dated 5/12/25, failed to show documentation of type site, swelling, drainage, and pain.</p> <p>- the pre-hemodialysis treatment dated 5/14/25, showed the dialysis site was perma cath. Furthermore, the post-hemodialysis treatment failed to show documentation of the type site, swelling, drainage, and pain.</p> <p>- the pre-hemodialysis treatment dated 5/16/25, failed to show documentation of the bruit and thrill. Furthermore, the post-hemodialysis treatment failed to show documentation of the type site, pain, and if there were new orders from dialysis center.</p> <p>On 5/19/25 at 1512 hours, an interview and concurrent medical record review for Resident 61 was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the hemodialysis communication record should be completed to ensure the dialysis residents were stable. LVN 5 further stated the communication record should be completed accurately to ensure the dialysis residents were properly assessed.</p> <p>On 5/21/25 at 0939 hours, an interview and concurrent medical record review for Resident 61 was conducted with the ADON. The ADON verified Resident 61 received dialysis Mondays, Wednesdays, Fridays, and Saturdays. The ADON further verified Resident 61's left arm fistula was being used as of 5/12/25, as per the physician's orders.</p> <p>On 5/21/25 at 1307 hours, an interview with Resident 61 was conducted in her room. Resident 61 verified the dialysis center used her left arm fistula during her dialysis treatments.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p> <p>2. Medical record review for Resident 45 was initiated on 5/18/25. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 45's MDS assessment dated [DATE], showed Resident 45 was cognitively intact.</p> <p>a. Review of Resident 45's Order Summary Report dated 5/20/25, showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- dated 10/3/24, for the pre and post dialysis weight to be taken at the dialysis center on Tuesdays, Thursdays, and Saturdays.</li> <li>- dated 2/1/25, for the dialysis center chair time at 0900 hours on Tuesdays, Thursdays, and Saturdays. Pick up time: at 0745 to 0800 hours. Dialysis access site: left arm AV shunt.</li> </ul> <p>Review of Resident 45's plan of care showed a care plan problem dated 6/8/23, addressing Resident 45's risk for impaired renal function and risk for complications related to the hemodialysis. The interventions included coordinating care with the dialysis center and send communication book to dialysis and review the book upon return.</p> <p>Review of Resident 45's Hemodialysis Communication Record showed the following missing documentation:</p> <ul style="list-style-type: none"> <li>- the post dialysis treatment section dated 5/5/25, failed to show the documentation of thrill, and failed to show the documentation of dialysis site type, swelling, drainage, and pain.</li> <li>- the post dialysis treatment section dated 5/8/25, failed to show the documentation of any swelling, drainage, and pain.</li> <li>- the post dialysis treatment section dated 5/10/25, failed to show the documentation of the dialysis site type, swelling, drainage, and pain; and failed to show documentation for post hemodialysis complication.</li> <li>- on 5/13/25, the dialysis center documented medications were given during hemodialysis, however the medication was not documented. The post dialysis treatment section failed to show the documentation of the dialysis site type, swelling, drainage, and pain.</li> <li>- on 5/15/25, the dialysis center failed to document the post-dialysis weight. Furthermore, the post dialysis treatment section failed to show the documentation of the dialysis site type, swelling, drainage, and pain.</li> <li>- the post-hemodialysis treatment section dated 5/17/25, failed to show the documentation of any swelling, drainage, and pain.</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/19/25 at 1545 hours, an interview and concurrent medical record review for Resident 45 was conducted with the ADON. The ADON stated for the residents receiving dialysis treatment, the facility's licensed nurse was responsible for completing the pre hemodialysis assessment and the staff at the dialysis center was responsible for completing the dialysis section, including the pre and post weights and documentation of the medications administered during the hemodialysis treatment; and upon return to the facility, the licensed nurse was responsible for completing the post hemodialysis treatment section. The ADON stated the licensed nurse was responsible for assessing the resident including assessing the hemodialysis site, to check for any bleeding, drainage, or pain. The ADON stated the hemodialysis communication record should be complete and accurate. The ADON further stated if any information was missing, the licensed nurse was expected to call the dialysis center to follow up. The ADON reviewed Resident 45's Hemodialysis Communication Records and verified the above findings.</p> <p>b. Review of Resident 45's Order Summary Report dated 5/20/25, showed a physician's order dated 4/17/25, for fluid restriction of 1,500 ml per day as follows: dietary to provide 1,080 ml total and nursing to provide 420 ml total (on the 0700 to 1500 shift: 180 ml, 1500 to 2300 shift:120 ml, and 2300 to 0700 shift: 120 ml) for end stage renal disease.</p> <p>Review of Resident 45's MAR for May 2025 showed the documentation for fluid restriction of 1500 ml per day as follows: nursing to provide 420 ml total, 180 ml during the 0700 to 1500 shift, 120 ml during the 1500 to 2300 shift, and 120 ml during the 2300 to 0700 shift:</p> <p>- from 5/1 to 5/17/25, for the day, evening, and night shifts, the fluid restriction was documented as X each shift.</p> <p>On 5/20/25 at 1026 hours, an interview and concurrent medical record review for Resident 45 was conducted with LVN 4. LVN 4 stated Resident 45 received hemodialysis treatments three times a week on Tuesdays, Thursdays, and Saturdays. LVN 4 stated Resident 45 was on fluid restriction of 1500 ml a day. LVN 4 stated the documentation of Resident 45's fluid intake was documented in the MAR by the licensed nurses each shift. LVN 4 reviewed Resident 45's MAR for 5/2025 and verified the above findings. When asked about the X documented each shift for Resident 45's fluid restriction, LVN 4 stated there should be a value documented to accurately monitor the amount of fluid that Resident 45 consumed. When asked if Resident 45's fluid intake was documented anywhere else in Resident 45's medical record, LVN 4 reviewed Resident 45's medical record and stated the amount of fluids Resident 45 consumed (during meals) was also not documented by the CNAs.</p> <p>On 5/20/25 at 1140 hours, an interview and concurrent medical record review for Resident 45 was conducted with the ADON. The ADON stated for the residents on hemodialysis treatment with an order for fluid restrictions, the resident's fluid intake should be documented by the licensed nurses in the MAR. The ADON reviewed Resident 45's MAR for 5/2025 and stated Resident 45's fluid restriction was documented incorrectly. Furthermore, when asked about the dietary fluid intake, the ADON stated there was no documentation of the total fluid intake per meal.</p> <p>c. Review of Resident 45's Order Summary Report dated 5/20/25, showed the following physician's orders:</p> <p>- dated 2/1/25, for the dialysis center chair time at 0900 hours on Tuesdays, Thursdays, and Saturdays. Pick up time: 0745 to 0800 hours. Dialysis access site: left arm AV shunt.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 3/27/25, to administer amlodipine (blood pressure medication) 10 mg one tablet by mouth daily for hypertension. To hold for SBP below 110 mmHg or heart rate below 60 bpm. May give medication upon return from dialysis.</p> <p>- dated 3/27/25, to administer carvedilol (blood pressure medication), 3.125 mg one tablet by mouth two times a day for hypertension. To hold for SBP less than 110 mmHg or pulse rate less than 60 bpm. May administer upon return from dialysis.</p> <p>- dated 4/29/25, to administer losartan (blood pressure medication) 50 mg one tablet by mouth daily. To hold for SBP less than 110 mmHg and may give medication after dialysis.</p> <p>Review of Resident 45's plan of care showed a care plan problem dated 4/29/21, addressing Resident 45's risk for cardiovascular symptoms or complications related to the diagnosis of hypertension and end stage renal disease. The interventions included administering medications as ordered and assess for effectiveness and side effects and report abnormalities to the physician.</p> <p>Review of Resident 45's Hemodialysis Communication Record dated 5/17/25, showed the dialysis center documented that the resident's BP was high lately, please monitor.</p> <p>Review of Resident 45's MAR for May 2025 showed the following:</p> <p>* for the amlodipine medication 10 mg one tablet daily, carvedilol medication 3.125 mg one tablet two times a day, and the losartan medication 50 mg one tablet daily, may give medication upon return from dialysis, the MAR showed:</p> <p>- on Tuesday 5/6/25 at 0900 hours, the licensed nurse documented AW for away from the center/facility,</p> <p>- on Thursday 5/8/25 at 0900 hours, the licensed nurse documented AW,</p> <p>- on Tuesday 5/13/25 at 0900 hours, the licensed nurse documented AW,</p> <p>- on Thursday 5/15/25 at 0900 hours, the licensed nurse documented AW, and</p> <p>- on Saturday 5/17/25 at 0900 hours, the licensed nurse documented AW.</p> <p>Review of Resident 45's medical record failed to show documentation the above blood pressure medications were administered to Resident 45 upon his return to the facility from the dialysis center for the above dates.</p> <p>On 5/21/25 at 0845 hours, an interview and concurrent medical record review for Resident 45 was conducted with the ADON. The ADON stated for the resident on the dialysis, the BP medication should be administered as per the physician's order. The ADON reviewed Resident 45's physician's order for the amlodipine, carvedilol, and losartan medications and stated the orders showed may administer the blood pressure medications after the dialysis. The ADON reviewed Resident 45's medical record and progress notes and stated she was unable to find the documentation showing the BP medications were administered to Resident 45 on the days Resident 45 returned from his dialysis treatments.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>

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  05/21/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 provide the pharmacy services to meet the resident needs for one of 21 final sampled residents (Resident 22), and two nonsampled residents (Residents 70 and 74).</p> <p>* Residents 70 and 74's controlled medication log did not match the MAR.</p> <p>* The facility failed to ensure the BP medication was held as per the physician's ordered hold parameters for Resident 22.</p> <p>These failures had the potential for poor health outcomes related to a potential unstable BP, and a delay in identifying potential diversion of the controlled medications.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Controlled Substances revised November 2022 showed the controlled substance inventory will be monitored and reconciled to identify loss and potential diversion. Reconciliation, dispensing, and disposition of controlled medications includes medication administration records.</p> <p>1. Medical record review for Resident 70 was initiated on 5/20/25. Resident 70 was readmitted to the facility on [DATE].</p> <p>Review of Resident 70's Antibiotic or Controlled Drug Record for tramadol HCl (a controlled pain medication) 50 mg tablet showed the doses were retrieved from the supply on the following dates:</p> <ul style="list-style-type: none"> <li>- On 2/10 and 2/25/25 at 2100 hours.</li> <li>- On 2/11/25 at 2200 hours.</li> <li>- On 2/21 and 2/24/25 at 2000 hours.</li> </ul> <p>Review of Resident 70's MAR for February 2025 failed to show the above doses were administered to the resident.</p> <p>On 5/20/25 at 0816 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated when the controlled medications were removed from the supply, the licensed nurses should document on the MAR once the medications were administered to the residents. The ADON reviewed Resident 70's Controlled Drug Record and MAR for February 2025 and verified the above tramadol HCl medication doses removed from the controlled medication supply were not documented in the MAR to show the medication were administered. The ADON stated the above doses should have been documented on the the resident's MAR.</p> <p>2. Closed medical record review for Resident 74 was initiated on 5/20/25. Resident 74 was discharged from the facility on 5/1/25.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 74's Antibiotic or Controlled Drug Record for Norco (a controlled pain medication) 5-325 mg tablet showed the doses were retrieved from the supply on the following dates:</p> <ul style="list-style-type: none"> <li>- On 1/3/25 at an illegible time.</li> <li>- On 1/4/25 at 1329 hours.</li> <li>- On 1/5/25 at 1400 hours.</li> <li>- On 1/14/25 at 1700 hours.</li> </ul> <p>Review of Resident 74's MAR for January 2025 failed to show the above Norco doses were administered to the resident.</p> <p>On 5/20/25 at 0816 hours, an interview and concurrent medical record review for Resident 74 was conducted with the ADON. The ADON reviewed Resident 74's Controlled Drug Record and MAR for 1/2025 and verified the above doses removed from the controlled medication supply were not documented in the MAR to show the medication were administered. The ADON stated the above doses should have been documented on the the resident's MAR.</p> <p>3. Review of the facility's P&amp;P titled Administering Medications revised 4/2019 showed the medications are administer in accordance with the prescriber orders, including any required time frame.</p> <p>Medical record review for Resident 22 was initiated on 5/18/25. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 22's Order Summary Report showed a physician's order dated 5/13/25, to administer midodrine HCl (a medication used to treat low BP) 5 mg one tablet via GT two times a day for hypotension (low blood pressure), and to hold the medication if the SBP greater than 130 mmHg.</p> <p>Review of Resident 22's MAR for May 2025 showed the following documentation:</p> <ul style="list-style-type: none"> <li>- Resident 22 was administered midodrine 5 mg one tablet two times a day from 5/14 to 5/18/25 at 0900 and 1700 hours. The MAR failed to show the documentation of Resident 22's BP readings prior to the administration of the midodrine medication.</li> </ul> <p>Further review of Resident 22's MAR for May 2025 showed Resident 22 was administered the lisinopril (blood pressure medication) 10 mg one tablet via GT on the following dates and time, with the following documented BP readings:</p> <ul style="list-style-type: none"> <li>- on 5/14/25 at 0900 hours, the BP was 136/78 mmHg, and</li> <li>- on 5/17/25 at 0900 hours, the BP was 145/70 mmHg.</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/20/25 at 0804 hours, an interview and concurrent medical record review for Resident 22 was conducted with the ADON. The ADON stated prior to the administration of the midodrine medication, the licensed nurses were expected to obtain the resident's BP and administer the midodrine medication as ordered by the physician. The ADON stated the licensed nurses should document the BP readings in the MAR, and if the licensed nurses were unable to document the BP readings in the MAR, then the licensed nurses should document in the resident's progress notes. The ADON reviewed Resident 22's medical record and verified the above findings. The ADON stated there was no documentation of Resident 22's BP readings prior to the administrations of the midodrine medication. The ADON further stated based on the BP readings documented on 5/14 and 5/17/25 at 0900 hours, the midodrine medication should have been held.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 5.13%. One of three licensed nurses (LVN 1) was found to have made errors during the medication administration observation.</p> <p>* LVN 1 failed to administer the complete dose for two of Resident 22's medications when significant residual of the medications were observed in the medication cups after administering the zinc (supplement) medication and vitamin D3 (supplement) medication via GT to Resident 22.</p> <p>This failure had the potential to negatively affect the resident's health conditions and posed the risk for possible complications or delay in interventions.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Administering Medications revised 4/2019 showed medications are administered in accordance with prescriber orders.</p> <p>Review of the facility's P&amp;P titled Administering Medications through an Enteral Tube (also known as a feeding tube, is a flexible tube inserted into the digestive tract to deliver nutrition and fluids to patients who cannot eat or drink normally) revised 11/2018 showed to dilute the medication by:</p> <ul style="list-style-type: none"> <li>a. remove plunger from syringe and add medication and appropriate amount of water to dilute,</li> <li>b. dilute crushed (powdered) medication with at least 30 ml purified water (or prescribed amount).</li> </ul> <p>On 5/19/25 at 0834 hours, a medication administration observation for Resident 22 was conducted with LVN 1. LVN 1 prepared and administered Resident 22's medications which included the following:</p> <ul style="list-style-type: none"> <li>- one tablet of metformin (diabetic medication) 1000 mg,</li> <li>- one tablet of amlodipine (blood pressure medication) 10 mg,</li> <li>- one tablet of lisinopril (blood pressure medication) 10 mg,</li> <li>- one tablet of baclofen (muscle relaxant) 5 mg,</li> <li>- one capsule of duloxetine (antidepressant medication) delayed release 30 mg,</li> <li>- one tablet of Eliquis (anticoagulant medication) 5 mg,</li> <li>- one capsule of gabapentin (anticonvulsant) 300 mg,</li> <li>- one tablet of aspirin (antiplatelet) 81 mg,</li> <li>- one tablet of vitamin C 500 mg,</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- one tablet of vitamin D3 25 mcg,</li> <li>- one tablet of zinc oxide (supplement) 50 mg,</li> <li>- one capsule of Probiotic (supplement),</li> <li>- 15 units of Lantus (diabetes medication)</li> <li>- 15 ml of potassium chloride (electrolyte supplement) 40 mEq, and</li> <li>- 15 ml of multi-vite (supplement).</li> </ul> <p>LVN 1 was observed administering the above medications to Resident 22 via the GT. After administering the medications, two medication cups were observed with significant amount of white-colored medication residue at the bottom and surrounding the walls of the medication cups.</p> <p>On 5/19/25 at 0953 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 verified the above findings and identified the medications inside the two medication cups were the zinc and vitamin D3 medications. LVN 1 stated during the administration of the medications via the GT, if medication residual was observed in the medication cup, water should be added and the solution thoroughly mixed, so the complete dose of the medication would be administered as ordered.</p> <p>On 5/21/25 at 0845 hours, an interview was conducted with the ADON. The ADON stated for the administration of the ordered medications via the GT, the licensed nurses were expected to ensure the medications were completely crushed and mixed with water. The ADON further stated if the medication residue was observed in the medication cups, the licensed nurse should add more water and mix the medication to ensure the complete dose was administered to the resident.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to store the drugs and biologicals in a safe manner for two of two medications rooms (Medication Rooms A and B) and three of three medication carts (Medication Carts A, B, and C).</p> <ul style="list-style-type: none"> <li>* The facility failed to remove the expired medications after the discard after or use-by date.</li> <li>* The facility failed to ensure proper labeling of the eye drop medication with the opened date.</li> <li>* The facility failed to remove the discontinued medications from the medication cart for Residents 10 and 50.</li> <li>* The facility failed to ensure the orally administered medications were stored separately from externally used medications.</li> </ul> <p>These failures had a potential to negatively impact residents' physiological well-being and posed the risk of unauthorized access, drug diversion, and medication administration errors; and posed the risk for cross contamination of the medications.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Storage in the Facility revised 1/2025 showed orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.</p> <p>Review of the facility's P&amp;P titled Medication Labeling and Storage (undated), showed the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Multi-dose vials that have been opened or accessed (e.g., needle punctures) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the opened vial.</p> <p>1. On 5/18/25 at 1230 hours, an inspection of Medication Cart B and concurrent interview was conducted with LVN 5. The following was observed:</p> <ul style="list-style-type: none"> <li>- one box of alendronate sodium (osteoporosis medication) 70 mg tablets stored in the same compartment as the bisacodyl (laxative) 10 mg suppositories.</li> <li>- an opened vial of insulin aspart (medication to lower blood sugar level) was labeled with the opened date of 4/8/25 (opened for 40 days). The label showed to discard the unused portion after 28 days.</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- an opened bottle of brimonidine-timolol (medication to lower eye pressure) eye drops, with no opened date. The label showed to discard the unused portion after 28 days.</p> <p>- a bubble pack containing tramadol (narcotic medication) 50 mg for Resident 50, with the label showing to give one tablet every eight hours as needed for moderate to severe pain for six days. The fill date showed 3/20/25.</p> <p>However, review of Resident 50 's medical record failed to show an active order for the tramadol medication.</p> <p>- a bubble pack containing zolpidem (sedative-hypnotic medication) 5 mg for Resident 10, with the label showing to administer one tablet every night at bedtime as needed until 5/11/25, and</p> <p>- a bubble pack containing zolpidem 5 mg with the instruction to administer one tablet every night at bedtime for 30 days. The fill date showed 3/27/25.</p> <p>However, review of Resident 10's medical record failed to show an active order for the zolpidem medication.</p> <p>LVN 5 verified the above findings. LVN 5 stated when the narcotic medications were changed or discontinued, the previous narcotic bubble pack (in the medication cart) should be removed from the medication cart and given to the DON, by the end of the shift.</p> <p>2. On 5/19/25 at 1105 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 6. A Novolog (insulin-medication to lower blood sugar level) flexpen was observed with the opened date of 4/15/25. The label showed to discard the unused portion after 28 days. LVN 6 verified the above findings and stated the Novolog medication should have been discarded after 28 days.</p> <p>On 5/21/25 at 0845 hours, an interview was conducted with the ADON. The ADON stated the licensed nurse assigned to the medication cart was responsible for the storage of the medication cart, including the availability of the medication and cleanliness of the medication cart. The ADON stated the licensed nurse was responsible for removing the discontinued medications from the cart, once stopped or when the medication was not in use. The ADON stated the discontinued narcotic medications should be removed from the medication cart and given to the DON as soon as the medication was discontinued. The ADON further stated the oral and suppository medications should not be stored together in the same compartment due to the potential risk of administering the medication to the resident incorrectly. The ADON stated all the insulin pens and insulin vials, as well as the eye drops, should be labeled with the opened date to ensure the medication would be appropriately discarded after the discard by date.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p> <p>3. On 5/18/25 at 1145 hours, an inspection of Medication Storage Room A and concurrent interview was conducted with LVN 2. The following was observed:</p> <p>- a box of bisacodyl 10 mg stimulant laxative suppositories (a medication used to relieve constipation) was stored together with oral medications on the first lower shelf of the medication cabinet.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- the floor was observed with dark visible dust, two spoons, white crumpled plastic, and a piece of brown cut paper.</p> <p>4. On 5/18/25 at 1205 hours, an inspection of Medication Storage Room B and concurrent interview was conducted with LVN 2. The following was observed:</p> <ul style="list-style-type: none"> <li>- acetylcysteine 10% solution for inhalation or oral administration (a medication used as acetaminophen antidote) was stored beside lidocaine 4% pain relief patches (a medication used to relieve pain).</li> <li>- a bottle of doxycycline hyclate capsules had an illegible expiration date.</li> </ul> <p>5. On 5/18/25 at 1244 hours, an inspection of the Medication Cart A and concurrent interview was conducted with LVN 2. The following was observed:</p> <ul style="list-style-type: none"> <li>- a discontinued medication fluocinonide 0.05% topical solution (a medication used to relieve redness, itching, swelling or other discomfort caused by skin condition) was not properly disposed.</li> </ul> <p>LVN 2 verified the oral medications and external medications should be stored separately, and Medication Storage Room A should be kept clean and sanitary. LVN 2 also acknowledged the expiration dates of the stored medications should be legible, and the discontinued medication should be properly disposed of. LVN 2 verified the above findings.</p> <p>On 5/21/25 at 1240 hours, an interview was conducted with the ADON. The ADON verified the above findings.</p>

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  05/21/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, facility document review, and facility P&amp;P review, the facility failed to ensure the menu was followed when preparing food for the residents.</p> <p>* The facility failed to ensure [NAME] 1 followed the recipe when preparing pureed spaghetti. This failure had the potential for not providing nutritional meals to meet the needs of the residents who were on pureed diet.</p> <p>Findings:</p> <p>Review of the facility's document titled Diet Type Report dated 5/18/25, showed six residents received pureed food prepared from the kitchen.</p> <p>Review of the facility's diet Menus dated 5/19/25, showed the lunch menu included spaghetti/meat sauce, tossed salad dressing, garlic bread, banana strawberry cup, and milk 2%.</p> <p>Review of the facility's P&amp;P titled Food: Quality, Palatability dated 2/2023 showed food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. The P&amp;P further showed the cook(s) prepared food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention.</p> <p>Review of the facility's recipe titled P (Puree) Spaghetti/Meatsauce dated 2025 spring showed for puree spaghetti to place the portions of spaghetti needed into a food processor and to process to a fine texture. For every five portions needed, add one cup of hot water and one tbsp of margarine and nonfat dry milk powder. Process until smooth with a rubber spatula, scrape down sides of the bowl; reprocess 30 seconds. Under the section note showed pureed spaghetti tends to thicken as it sits on the serving line, so add liquid accordingly.</p> <p>On 5/19/25 at 1022 hours, an observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 was preparing pureed spaghetti. [NAME] 1 was observed measuring spaghetti. [NAME] 1 stated he was preparing for seven servings of puree spaghetti and added seven scoops of four-ounce ladle of spaghetti in blender. [NAME] 1 was then observed adding one and half cup of hot water and blended the spaghetti. [NAME] 1 was not observed adding margarine and non-fat dry milk powder in the pureed spaghetti.</p> <p>On 5/19/25 at 1053 hours, an interview and concurrent document review was conducted with [NAME] 1. [NAME] 1 verified the above observations and stated he did not add margarine and dry milk powder while preparing pureed spaghetti. [NAME] 1 verified the recipe for spaghetti showed to add margarine and dry milk powder. [NAME] 1 stated he should have followed the recipe for the pureed spaghetti and added margarine and dry milk powder.</p> <p>On 5/19/25 at 1131 hours, an interview was conducted with the DSS. The DSS was informed of the above findings. The DSS stated the cook should follow the recipe while preparing pureed food for the residents. The DSS acknowledged the above findings.</p>		

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  05/21/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and facility document review, the facility failed to ensure the food safety and sanitation guidelines were followed when:</p> <ul style="list-style-type: none"> <li>* The facility failed to ensure the food preparation equipment was air dried.</li> <li>* The facility failed to ensure the kitchen equipment and utensils were maintained in a sanitary condition.</li> <li>* The facility failed to ensure safe storage of food items.</li> </ul> <p>These failures had the potential to result in foodborne illnesses for residents receiving kitchen services.</p> <p>Findings:</p> <p>Review of the facility document titled Diet Type Report dated 5/18/25, showed 87 of 94 residents were receiving food from the kitchen.</p> <p>1. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow.</p> <p>On 5/18/25 at 0802 hours, an observation of the kitchen and concurrent interview was conducted with the DSS. A red blender was observed covered with the lid in the food preparation area. When the DSS opened the lid of the blender, the blender was observed to be stored wet. The DSS verified the observation and stated the staff should have air dried the blender before storing.</p> <p>2. According to the USDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces.</p> <p>On 5/18/25 at 0802 hours, during an observation in the kitchen and concurrent interview with the DSS, the following was observed:</p> <ul style="list-style-type: none"> <li>- A red cutting board ready to use was observed to be heavily marred with brownish discoloration and with food residue. The DSS verified the observation and stated the red cutting board should have been thoroughly cleaned and needed to be replaced.</li> </ul> <p>(continued on next page)</p>		

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  05/21/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Multiple red insulated plate bases on the rack were observed with dust. The DSS verified the observation and stated multiple red insulated plate base were ready to use and should have been cleaned thoroughly.</p> <p>- Two oven tray sheet pan was observed with heavy dark brown residue. The DSS verified the observation and stated the above oven tray sheet pan should have been thoroughly cleaned.</p> <p>3. According to the USDA Food Code 2022, Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking .refrigerated, ready to eat, time temperature control for safety food, prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of seven days. The day of preparation shall be counted as day one.</p> <p>On 5/18/25 at 0802 hours, an observation of the only walk-in refrigerator in the facility and concurrent interview with the DSS was conducted. The following was observed:</p> <p>- On the second shelf from the top of the walk-in refrigerator two bins were observed with chopped strawberries and blueberries with no date to show when they were prepared. The DSS verified the observation and stated all the prepared ready to eat food items in the facility should be labeled with the current date and use by date. The DSS further stated the two bins with the chopped strawberries and blueberries should have been dated.</p> <p>- On the top shelf of the refrigerator, 31 small cups of ranch dressing were observed with prepared date of 5/13/25, and use by date of 5/16/25. The DSS verified the observation and stated the above cups of the ranch dressing passed the use by date and should have been discarded.</p> <p>On 5/21/25 at 1346 hours, the Administrator, DSD, DSS, and RD Consultant were informed and acknowledged the above findings.</p>

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  05/21/2025
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 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to implement their P&amp;P to ensure proper storage of food in the residents' refrigerator as evidenced by:</p> <p>* Residents' refrigerator for food brought from the outside was not maintained in a proper temperature. In addition, the food items were in the residents' refrigerator not labeled with the current date and use by dates as per the facility's P&amp;P. These failures had the potential to result in foodborne illnesses in a highly susceptible resident population.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Food Brought by Family/Visitors revised 3/31/25, showed the facility to provide the residents with the option of having food prepared by the resident's family brought into the facility. When the food items are intended for later consumption, responsible staff member will label food with the resident's name, and the current date and use by date. Items will be thrown out after 48 hours. Further review of the P&amp;P showed refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and equipped with working thermometer, have temperature monitored daily for refrigeration less than 41 degrees Fahrenheit and freezer less than or equal to 0 degrees Fahrenheit.</p> <p>On 5/20/25 at 0849 hours, during an inspection of the residents' refrigerator and concurrent interview with LVN 2, the following was observed:</p> <ul style="list-style-type: none"> <li>- Only resident refrigerator in Station A was observed partially open, refrigerator was observed full of the resident's food preventing the door from properly closing. The temperature inside the resident refrigerator showed 70 degrees Fahrenheit.</li> <li>- A plastic container with two tacos was observed not having a label with the current date and use by date.</li> </ul> <p>LVN 2 verified the above observations and stated the door of the refrigerator should be completely closed and the temperature of the refrigerator should be maintained less than 41 degrees Fahrenheit. LVN 2 stated she would discard the food items from the refrigerator. LVN 2 further stated a plastic container with two tacos should have been labeled with current date and use by date.</p> <p>On 5/20/25 at 1517 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to properly dispose of the unused items. This failure had the potential to attract rodents and pests that carried a disease.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Pest Control dated 5/2008 showed the garbage and trash are not permitted to accumulate and are removed from the facility daily.</p> <p>Review of the facility's P&amp;P titled Grounds dated 5/2008 showed facility grounds shall be maintained in a safe and attractive manner. Maintenance shall be responsible for keeping the grounds free of litter.</p> <p>On 5/19/25 at 0857 hours, an observation and concurrent interview was conducted with the Maintenance Director. A big pile of items including five plastic storage drawers, wheelchair, laundry cart in despair, soiled laundry bin, bed wires, plastic bags, metal boxes, front wheel walker, bed side commode, two trash bins, etc. , with the dust on and around of the above items were observed in the facility compound at the left side of the facility's building. The Maintenance Director verified the observation and stated most of the above items were not being used and needed to be discarded. The Maintenance Director acknowledged the above pile of items could attract rodents and pests that carried a disease.</p> <p>On 5/21/25 at 1021 hours, a follow-up observation of the facility compound and concurrent interview was conducted with the Maintenance Director. During the observation, seven plastic storage drawers, wheelchair, two trash bins, and one metal cart were stored in an organized manner. The Maintenance Director stated he cleaned the compound at the left side of the facility's building and discarded items that were not being used including metal boxes, soiled laundry bin, laundry cart, front wheel walker, and bed wires, etc.</p> <p>On 5/21/25 at 1617 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.</p>		

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  05/21/2025
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>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 3. Medical record review for Resident 3 was initiated on 5/18/25. Resident 3 was admitted to the facility on [DATE].</p> <p>On 5/20/25 at 1032 hours, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. A review of Resident 3's EHR was conducted with the ADON. Resident 3's EHR contained Resident 343's PASRR Level 1 screening. The ADON verified Resident 343's PASRR Level 1 screening was uploaded to Resident 3's EHR in error.</p> <p>Based on interview, medical record review and facility P&amp;P review, the facility failed to ensure the complete and accurate medical records for four of 21 final sampled residents (Residents 3, 9, 10, and 19).</p> <p>* The facility failed to ensure Residents 9 and 19's MAR documentation for months of April and May 2025 were accurate regarding monitoring for the side effects for apixaban use (a medication used to prevent blood clots).</p> <p>* The facility failed to ensure Resident 19's facesheet listed accurate diagnoses. The facility included a diagnosis of unspecified schizoaffective disorder when the resident did not have a history of and was not receiving medications for schizoaffective disorder.</p> <p>* Resident 3's electronic health record (EHR) contained another resident's (Resident 343) PASRR Level 1 screening.</p> <p>* The facility failed to ensure Resident 10's POLST Section D was accurate.</p> <p>* The facility failed to ensure Resident 92's discharge summary was completed.</p> <p>These failures had the potential for the residents' care needs not being met as their medical information were inaccurate.</p> <p>Findings:</p> <p>Review of the facility P&amp;P titled Nursing Documentation dated 8/27/22, showed the nursing documentation is to communicate patient's status and provide complete, comprehensive and accessible accounting of care and monitoring provided, will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's condition, situation, and complexity. Documentation for subsequent and/routine care and procedures may be completed by exception or the use of a checklist, flow charts, or other documentation tools.</p> <p>1. Medical record review for Resident 9 was initiated on 5/18/25. Resident 9 was admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 9's MAR for 5/2025 showed the following physician's orders:</p> <p>(continued on next page)</p>

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  05/21/2025
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>- dated 12/11/24, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, and or vital signs, shortness of breath, nose bleeds. To document Y if monitored and none of the above observed, N if monitored and any of the above was observed, and select chart code other/see nurses' notes and progress note findings every shift apixaban use. The documentation showed LVN 8 documented N on the following dated: 5/2, 5/9, 5/10, 5/16, and 5/17/25. The licensed progress notes showed no documentation of any change of condition from the dates identified.</p> <p>On 5/20/25 at 1156 hours, an interview and concurrent medical record review for Resident 9 was conducted with the ADON. The ADON was asked about the facility's process if there were any changes of condition documented in the MAR. The ADON stated there should be documentation of the change in condition and the primary physician should be informed. The ADON verified by calling LVN 8 for clarification on her MAR documentation. The ADON stated LVN 8 entered a typographical error from the above dates identified for Residents 9's MARs. The ADON also stated Resident 9 did not show any change in condition from the use of the apixaban and did not receive any reports of any change in condition from other licensed staff .</p> <p>2. Medical record review for Resident 19 was initiated on 5/18/25. Resident 19 was admitted to the facility on [DATE].</p> <p>a. Review of Resident 19's MAR for 4/2025 showed the following physician's orders:</p> <p>- dated 4/8/24, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, and or vital signs, shortness of breath, nose bleeds. To document Y if monitored and none of the above observed, N if monitored and any of the above was observed, and select chart code other/ see nurses' notes and progress note findings every shift for apixaban use. The documentation also showed LVN 8 documented N on the following dates 4/12, 4/18, and 4/25/25. In addition, the licensed progress notes showed no documentation of any change in condition from the above dates identified.</p> <p>On 5/20/25 at 1156 hours, an interview and concurrent medical record review for Resident 19 was conducted with the ADON. The ADON was asked about the facility's process if there were any changes of condition documented in the MAR. The ADON stated there should be documentation of the change of condition and the primary physician should be informed. The ADON verified by calling LVN 8 for clarification on her MAR documentation. The ADON stated LVN 8 entered a typographical error from the above dates identified for Resident 19's MARs. The ADON also stated Resident 19 did not show any change of condition from the use of the apixaban and did not receive any reports of any change of condition from other licensed staff .</p> <p>b. Review of the Resident 19's facesheet diagnosis information showed a diagnosis of unspecified schizoaffective disorder with an onset date of 7/4/21.</p> <p>Review of Resident 19's H&amp;P examination dated 7/8/21, showed Resident 19's admitting history, past medical history, and assessment and plan did not include findings of unspecified schizoaffective disorder.</p> <p>Review of Resident 19's Order Summary for the month of 5/2025 did not show any medication prescribed by the physician for unspecified schizoaffective disorder.</p> <p>(continued on next page)</p>		

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  05/21/2025
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>On 5/19/25 at 0734 hours, an interview and concurrent medical record review for Resident 19 was conducted with the ADON. The ADON was asked for any documentation to show Resident 19 was admitted with the diagnosis of unspecified schizoaffective disorder. The ADON was not able to find any documentation on admission from the acute care hospital discharge records to the facility to show the diagnosis of unspecified schizoaffective disorder.</p> <p>On 5/20/25 at 1111 hours, an interview and concurrent medical record review for Resident 19 was conducted with the MDS coordinator. The MDS coordinator was asked why the diagnosis of schizoaffective disorder documented on Resident 19's facesheet was not triggered in the MDS. The MDS coordinator stated she was not employed at the facility in 2021. The MDS coordinator further verified she modified the MDS finding of active diagnosis of schizophrenia on 5/19/25, from yes to no and added she clarified with the primary physician to discontinue the medical diagnosis of schizoaffective disorder since there was never a diagnosis of schizoaffective disorder. The MDS coordinator verified that it could have been triggered due to typographical error way back in 2021 from the previous MDS who initiated the diagnosis.</p> <p>On 5/21/25 at 1240 hours, an interview was conducted with the ADON. The ADON verified the above findings.</p> <p>4. Medical record review for Resident 10 was initiated on 5/20/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 10's H&amp;P examination dated 3/12/25, showed Resident 10 had advanced dementia.</p> <p>Review of Resident 10's Physician Orders for Life-Sustaining Treatment (POLST) dated 1/24/25, under Section D showed Resident 10 had an advance directive but was not available.</p> <p>Review of Resident 10's medical record failed to show an evidence of advance directive.</p> <p>Review of Resident 10's Social Services Assessment and Documentation v1 dated 3/13/25, under Section A question 5b, showed Resident 10 had no advance directive.</p> <p>On 5/20/25 at 1145 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD stated the POLST was reviewed upon admission of the resident and reviewed during the IDT meeting. The SSD further stated the purpose of the advance directive was for the resident to have their medical decion maker decide when they did not have the capacity to make their own decisions. The SSD reviewed Resident 10's POLST and medical record and was not able to show Resident 10's advance directive.</p> <p>On 5/20/25 at 1445 hours, a follow-up interview was conducted with SSD. The SSD stated she contacted Resident 10's family member regarding Resident 10's advance directive. Resident 10's family member confirmed Resident 10 did not have an advance directive. The SSD stated upon Resident 10's admission, she discussed the advance directive with Resident 10 and the resident's family member. The SSD gave Resident 10's family member the advance directive form to complete. The SSD stated she should have followed up with Resident 10's family member to complete and submit the form. The SSD verified Resident 10's POLST should have been updated to accurately show Resident 10 did not have an advance directive.</p> <p>(continued on next page)</p>		

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  05/21/2025
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>On 5/21/25 at 1123 hours, an interview was conducted with the DSD and Administrator. The DSD and Administrator were informed and acknowledged the above findings for Resident 10.</p> <p>5. Medical record review for Resident 92 was initiated on 5/19/25. Resident 92 was admitted to the facility on [DATE].</p> <p>Review of Resident 92's H&amp;P examination dated 3/21/25, showed Resident 92 had the capacity to understand and make decisions.</p> <p>Review of Resident 92's Physician Order Summary showed a physician's order dated 3/27/25, to discharge Resident 92 to an acute care hospital due to increased weakness and abnormal labs.</p> <p>Review of Resident 92's eINTERACT Transfer Form v5 dated 3/27/25 at 1313 hours, showed Resident 92 was discharged to the acute care hospital.</p> <p>Review of Resident 92's discharge summary failed to show the basis for Resident 92's discharge to the acute care hospital on 3/27/25.</p> <p>On 5/19/25 at 1441 hours, an interview and concurrent medical record review for Resident 92 was conducted with ADON. The ADON verified Resident 92 was discharged to the acute care hospital on 3/27/25. The ADON reviewed Resident 92's discharge summary and verified the physician did not check off the reason for the resident's discharge to the acute care hospital. The ADON stated the discharge summary was not complete because the physician should have provided the reason why it was necessary for Resident 92 to be discharged .</p> <p>On 5/21/25 at 1123 hours, an interview was conducted with the DSD and Administrator. The DSD and Administrator were informed and acknowledged the above findings for Resident 92.</p>

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  05/21/2025
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on interview, and facility document review, the facility failed to ensure the QAPI committee implemented and monitored the effectiveness of their plan of correction for improvement of repeated deficient practice cited at F552, F812, and F883. This failure had the potential to affect the quality of care for all the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's Quality Assurance Performance Improvement Program showed the QAPI will develop monitoring tools that provide an effective mechanism to ensure residents receive the necessary care. The QAPI will develop plans of correction and evaluate corrective actions taken to obtain desired results.</p> <p>Review of the POC submitted by the facility to the CDPH, L&amp;C Program from the last recertification survey completed on 6/13/24, showed the following:</p> <ul style="list-style-type: none"> <li>- For cited F552, the Medical Records staff and Medical Records Director will audit the informed consents and medication records for compliance for three months. Findings will be brought to the monthly QA committee.</li> <li>- For cited F812, the District Manager will perform monthly Unit Inspections for three months, to include check label and dating compliance. The RD or designee will perform a monthly sanitation audit of the kitchen, for three months. Findings will be brought to the QA committee.</li> <li>- For cited F883, the IP will maintain a log of the residents and their immunization status Monday-Friday. Medical records will audit the immunization record and give a copy to the DON and IP Monday-Friday. The IPN will report all trends to the monthly QA committee meeting for three months.</li> </ul> <p>On 5/21/25 at 1502 hours, an interview and concurrent QAPI Program and facility document review was conducted with the Administrator. The Administrator was unable to show documentation the QAPI committee monitored the effectiveness of the facility's plan of correction for F552, F812, and F883.</p>

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  05/21/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Medical record review for Resident 595 was initiated on 5/18/25. Resident 595 was admitted to the facility on [DATE].</p> <p>Review of Resident 595's H&amp;P examination dated 4/29/25, showed the resident had the capacity to understand and make decisions.</p> <p>On 5/18/25 at 0950 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with LVN 5 in Resident 595's room. One box of Caprisun juice and Coffeemate creamer were observed on the floor at bedside. LVN 5 verified the findings. LVN 5 stated the resident's personal belongings should not be placed on the floor for infection control. LVN 5 further stated the items could be stored in the resident's bedside drawers.</p> <p>On 5/21/25 1020 hours, an interview was conducted with the ADON. The ADON acknowledged the findings and stated the resident's personal belongings or food items should not be placed on the floor to ensure infection control was maintained.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The Administrator and DSD were informed and acknowledged the above findings.</p> <p>Based on observation, interview, facility document review, and facility P&amp;P review, the facility failed to ensure the appropriate infection control practices designed to provide the safe and sanitary environment were implemented as evidenced by:</p> <ul style="list-style-type: none"> <li>* The facility failed to ensure the basins found inside the shared restrooms in Rooms A, B, C, and D were properly labeled and stored.</li> <li>* The facility failed to ensure Resident 595's personal food items maintained infection control.</li> </ul> <p>These failures had the potential to spread communicable diseases to the vulnerable residents in the facility.</p> <p>Findings:</p> <p>1.a. On 5/18/25 at 0836 hours, an observation of the shared restroom for Rooms A (occupied by Residents 4 and 29) and B (occupied by Residents 13 and 15) and concurrent interview was conducted with LVN 7. An unlabeled basin was observed on top of the toilet tank. When LVN 7 was asked which resident that the unlabeled basin was belonged to, LVN 7 stated he did not know since the unlabeled basin was placed in the shared restroom. LVN 7 verified the basin should have been labeled with the resident's name for infection prevention and control. LVN 7 further stated the unlabeled basin would be thrown away.</p> <p>b. On 5/18/25 at 0913 hours, an observation of the shared restroom for Rooms C (occupied by Residents 28 and 57) and D (occupied by Residents 30 and 78) and concurrent interview was conducted with LVN 6. Two unlabeled basins were found on top of the toilet tank. LVN 6 was asked about the facility's process regarding the two unlabeled basins. LVN 6 verified the unlabeled basins found in the shared restroom should be thrown away for infection prevention and control.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 1240 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p>

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  05/21/2025
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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure one of five final sampled residents (Resident 12) reviewed for influenza vaccinations was offered the influenza vaccination. This failure placed Resident 12 at risk for increased risk of infection and the transmission of influenza.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Influenza Vaccine revised 3/2022 showed all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. The P&amp;P further showed a resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record.</p> <p>Medical record review for Resident 12 was initiated on 5/18/25. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 12's H&amp;P examination dated 7/7/24, showed the resident had the capacity to make medical decisions.</p> <p>Review of Resident 12's facility document titled Immunization Report from 11/1/23 to 5/31/25, showed Resident 12's current influenza vaccine was administered on 11/4/23.</p> <p>Further review of Resident 12's medical record failed to show an influenza vaccine was offered to the resident or resident's representative to accept or decline the influenza vaccine.</p> <p>On 5/20/25 at 0909 hours, an interview and concurrent medical record review for Resident 12 was conducted with the IP. The IP verified the above findings. The IP verified there was no documented evidence the influenza vaccine was offered annually after Resident 12's last influenza vaccine administration on 11/4/23. Moreover, the IP verified there was no documented evidence the influenza vaccination was offered to the resident or resident's representative. The IP stated the influenza vaccine should be offered annually. The IP further stated the consent forms for the influenza vaccines were provided to ensure the resident or resident representative were aware of the risk and benefits of the vaccine.</p> <p>On 5/21/25 at 0957 hours, an interview and concurrent medical record review for Resident 12 was conducted with the ADON. The ADON verified the above findings. The ADON stated the influenza vaccine was offered annually and consent was needed to be obtained. The ADON further stated the consent ensured the resident or resident representative were made aware of the risks and benefits from receiving or declining the vaccines offered by the facility.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and the DSD. The DSD stated the influenza vaccine should be offered annually and a new consent was offered. The Administrator and DSD were informed and acknowledged the above findings.</p>		

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  05/21/2025
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure one of five final sampled residents (Resident 12) reviewed for COVID-19 vaccination was offered the COVID-19 vaccination. This failure placed Resident 12 at risk for increased risk of infection and transmission of COVID-19.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Coronavirus Disease (COVID-19) - Vaccination of Residents COVID-19 Protocol, undated, showed each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. Residents are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine. Furthermore, the P&amp;P showed if the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination, or refusal, appropriate documentation is made in the resident's record.</p> <p>Medical record review for Resident 12 was initiated on 5/18/25. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 12's H&amp;P examination dated 7/7/24, showed the resident had the capacity to make medical decisions.</p> <p>Review of Resident 12's facility document titled Patient Informed Consent or Declination COVID-19 Vaccine dated 4/14/24, showed the resident's responsible party declined the COVID-19 vaccine.</p> <p>Further review of Resident 12's medical record failed to show a COVID-19 vaccination or consent was offered to the resident or resident's representative annually since the vaccination was last offered on 4/14/24.</p> <p>On 5/20/25 at 0909 hours, an interview and concurrent medical record review for Resident 12 was conducted with the IP. The IP verified the above findings. The IP verified there was no documented evidence the COVID-19 vaccine was offered annually after Resident 12 was last offered the COVID-19 vaccine on 4/14/24. Moreover, the IP verified there was no documented evidence the COVID-19 informed consent was offered to the resident or resident's representative. The IP verified the COVID-19 vaccine should be offered annually. Furthermore, the IP stated the consent forms for the COVID-19 vaccines were provided to ensure the resident or resident's representative were aware of the risks and benefits of the vaccine.</p> <p>(continued on next page)</p>		

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  05/21/2025
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 0957 hours, an interview and concurrent medical record review for Resident 12 was conducted with the ADON. The ADON verified the above findings. The ADON acknowledged a COVID-19 consent should have been offered and completed. The ADON further stated the consents ensured the resident or resident's representative were made aware of the risks and benefits in receiving or declining the vaccines offered by the facility.</p> <p>On 5/21/25 at 1330 hours, an interview was conducted with the Administrator and DSD. The DSD stated the COVID-19 vaccine should be offered annually and a new COVID-19 consent would need to be offered. The Administrator and DSD were informed and acknowledged the above findings.</p>