

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for five of 19 final sampled residents (Residents 4, 9, 11, 31, and 47). * The facility failed to follow the physician's order to administer the metoprolol (medications to treat high blood pressure) when Resident 4's systolic blood pressure (SBP) was above 110 mmHg and pulse rate above 55 beats per minute. This failure had the potential for Resident 4 to develop adverse effects from untreated hypertension, including cardiovascular complications. * The facility failed to notify the physician when Resident 9's blood sugar was more than 400 mmHg, as per the physician's order. This failure had the potential to result in delayed medical intervention, unmanaged hyperglycemia, and increased risk for serious complications such as hospitalization. * The facility failed to ensure the insulin administration sites were rotated as ordered by the physician for Residents 9, 11, 31 and 47. This failure had the potential to result in ineffective treatment, altered medication effectiveness/absorption, and tissue damage. Findings: 1. Review of the facility's P&P titled Medication Administration & General Guidelines dated 10/2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. - Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medication - Medications are administered in accordance with written orders of the attending physician. Medical record review for Resident 4 was initiated on 7/12/26. Resident 4 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 4's MDS 5-day PPS (Prospective Payment System) assessment dated [DATE], showed Resident 4's BIMS Summary Score was 13, indicating intact cognition. Review of Resident 4's Order Summary Report dated 7/14/26, showed a physician's order dated 6/26/26, to administer metoprolol 12.5 mg one tablet by mouth every 12 hours, hold if SBP was below (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	110 mmHg or pulse rate below 55 beats per minute for hypertension. Review of Resident 4's MAR for July 2026 failed to show the metoprolol 12.5 mg medication was administered on 7/6/26 at 0900 hours, when Resident 4's blood pressure was 142/86 mmHg and pulse rate 58 beats per minute. On 7/14/26 at 1329 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 3. LVN 3 verified Resident 4's metoprolol medication was held despite Resident 4's SBP and pulse rate being within ordered parameters. 2. Review of the facility's P&P titled Insulin Administration Purpose revised 3/2025 showed to provide guidelines for the safe administration of insulin. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). According to Taylor's Clinical Nursing Skills, seventh edition, the various sites used for subcutaneous injections are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (upper front) or dorsogluteal area (buttocks). It is necessary to rotate sites or areas for injections to prevent buildup of fibrous tissue and permit complete absorption of the medication. Medical record review for Resident 9 was initiated on 7/12/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 5/4/26, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 5/30/26, Humulin R (regular insulin) injection solution 100 unit/ml to inject subcutaneously as per sliding scale before meals and at bedtime for diabetes. The sliding scale directed staff to administer insulin if blood sugar: 60-150 mg/dl, to give 0 units of insulin; 151-200 mg/dl, to give 1 unit of insulin; 201-250 mg/dl, to give 2 units of insulin; 251-300 mg/dl, to give 3 units of insulin; 301-350 mg/dl, to give 4 units of insulin; 351-400 mg/dl, to give 5 units of insulin; and, 401-999 mg/dl, to give 6 units of insulin; (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify physician if blood sugar was below 70 mg/dl or above 400 mg/dl, and to rotate injection sites. - dated 6/19/26, to administer for Lantus Solostar (insulin glargine) 100 unit/ml to inject 23 units subcutaneously two times a day for diabetes, and to rotate injection sites. a. Review of Resident 9's MAR dated 7/1 to 7/31/26, showed on 7/7/26 at 1630 hours, Resident 9's blood sugar was 466 mg/dl, and 6 units of insulin was administered per the sliding scale. However, further review of Resident 9's MAR and medical record did not show documented evidence the physician was notified on 7/7/26 at 1630 hours, when Resident 9's blood sugar exceeded 400 mg/dl. b. Review of Resident 9's Location of Administration Report for July 2026 showed the Humulin R was administered at the same injection site on following dates and times: - on 7/9/26 at 1130 hours, insulin was administered to the LLQ (left lower quadrant) of the abdomen; - on 7/9/26 at 1630 hours, insulin was administered to the LLQ of the abdomen; - on 7/9/26 at 2022 hours, insulin was administered to the LLQ of the abdomen - on 7/10/26 at 1703 hours, insulin was administered to RLQ (right lower quadrant) of the abdomen; and - on 7/10/26 at 2008 hours, insulin was administered to RLQ of the abdomen. The report further showed the Lantus was administered at the same injection site on the following dates and times: -on 7/8/26 at 0854 hours, insulin was administered to the RLQ of the abdomen; -on 7/8/26 at 2102 hours, insulin was administered to the RLQ of the abdomen; - on 7/10/26 at 1042 hours, insulin was administered to the LLQ of the abdomen; - on 7/10/26 at 2007 hours, insulin was administered to the LLQ of the abdomen; - on 7/11/26 at 2141 hours, insulin was administered on RUQ (right upper quadrant) of the abdomen; - on 7/12/26 at 0948 hours, insulin was administered on RUQ of the abdomen; and - on 7/12/26 at 2050 hours, insulin was administered on RUQ of the abdomen. On 7/13/26 at 1129 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN¹. RN¹ verified the physician's order for the Humulin R required the staff to (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify the physician when the resident's blood sugar was below 70~mg/dL or above 400~mg/dL. RN~1 stated she was unable to locate any documentation to show the physician was notified when Resident~9's blood sugar was 466~mg/dL on 7/7/26 at 1630 hours. RN~1 stated the physician should have been notified when Resident~9's blood sugar exceeded 400~mg/dL. RN~1 further verified the physician's orders for Humulin R and Lantus, which instructed the staff to rotate injection sites. RN 1 stated insulin injection sites should be rotated with each administration. RN~1 reviewed the above administration locations for Resident 9 and verified the injection sites were not being rotated on the identified dates and times for both Humulin R and Lantus insulins. On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. a. Medical record review for Resident 11 was initiated on 7/12/26. Resident 11 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 8/12/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's Order Summary Report showed a physician's order dated 3/28/26, to administer insulin glargine (a long-acting insulin designed to manage blood sugar levels) 26 units subcutaneously before breakfast and at bedtime, to rotate the site of administration. Review of Resident 11's Location of Administration Report for July 2026 showed the insulin glargine was administered at the same injection site on the following dates and times: - dated 7/4/26 at 2100 hours, insulin was administered to the RLQ of the abdomen; - dated 7/5/26 at 0630 hours, insulin was administered to the RLQ of the abdomen; - dated 7/7/26 at 2100 hours, insulin was administered to the right arm; - dated 7/8/26 at 0630 hours, insulin was administered to the right arm; - dated 7/8/26 at 2100 hours, insulin was administered to the right arm; - dated 7/11/26 at 2100 hours, insulin was administered to the left arm; and - dated 7/12/26 at 0630 hours, insulin was administered to the left arm. On 7/13/26 at 1202 hours, an interview and concurrent medical record review for Resident 11 was conducted with LVN 2. LVN 2 verified the physician's orders for the insulin glargine before breakfast and at bedtime. LVN 2 stated prior to administering the insulin injection, the licensed nurse should check the MAR to see the last administration site. LVN 2 further stated the insulin injection sites should be rotated to prevent complications of the skin from repeated injection to the same site. LVN 2 reviewed Resident 11's MAR for July 2026 and verified the above findings when the insulin (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration sites were not rotated. On 7/14/26 at 1355 hours, an interview was conducted with the DON. The DON stated the license nurses need to follow the physician's order. The DON was informed and acknowledged above findings. On 7/15/26 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. b. Medical record review for Resident 47 was initiated on 7/12/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination dated 7/2/26, showed Resident 47 had the capacity to participate in medical decision-making and was able to understand the nature of his medical conditions, treatment recommendations, and potential risks and benefits. Review of Resident 47's Order Summary Report for July 2026, showed the following physician's orders: - dated 7/3/26, to administer Novolog FlexPen (blood glucose medication) 100 unit/ml inject as per sliding scale and to administer insulin for blood glucose as follows: - blood glucose of 0-149, give 0 unit of insulin; - blood glucose of 150-200, give 2 units of insulin; - blood glucose of 201-250, give 4 units of insulin; - blood glucose of 251-300, give 6 units of insulin; - blood glucose of 301-350, give 8 units of insulin; - blood glucose of 351-400, give 10 units of insulin; and - blood glucose of 401-999, give 12 units of insulin. Further instructions of the order showed to administer before meals and at bedtime and to rotate site of injection. Review of Resident 47's Location of Administration Report for July 2026 showed Resident 47's injection sites for the Novolog FlexPen were not rotated on the following dates and times: - on 7/3/26 at 1208 hours, insulin was administered to the left arm; - on 7/3/26 at 1605 hours, insulin was administered to the left arm; (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 7/5/26 at 1613 hours, insulin was administered to the left arm; - on 7/5/26 at 2124 hours, insulin was administered to the left arm; - on 7/6/26 at 1149 hours, insulin was administered to the right arm; and - on 7/6/26 at 1646 hours, insulin was administered to the right arm. On 7/13/26 at 1235 hours, an interview and concurrent medical record review for Resident 47 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the injection sites should be rotated as ordered to prevent complications of repeated injections to one site. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON stated injection sites for the insulin should be rotated. The DON stated repeated injections to the same location could cause a skin reaction or infection. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. c. Medical record review for Resident 31 was initiated on 7/12/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 6/27/26, showed Resident 31 had the capacity to understand and make decisions. Review of Resident 31's Order Summary Report showed the following physician's orders: - dated 6/28/26, to administer Lantus SoloStar (a long-acting insulin used once daily used to treat diabetes by controlling blood sugar for 24 hours) subcutaneous solution, to inject 5 units subcutaneously at bedtime. Rotate site of injection; and - dated 6/26/26, to administer Humalog (Insulin Lispro, a rapid-acting insulin used to control high blood sugar) to inject as per sliding subcutaneously before meals and at bedtime. Review of Resident 31's Location of Administration Report for June and July 2026 showed the Lantus SoloStar insulin and the Humalog insulin were administered consecutively on the same injection sites on the following dates and times: - dated 6/27/26 at 0608 hours, Humalog insulin was administered to the left arm; - dated 6/27/26 at 1347 hours, Humalog insulin was administered to the left arm; - dated 6/28/26 at 0630 hours, Humalog insulin was administered to the left arm; - dated 6/28/26 at 1614 hours, Humalog insulin was administered to the left arm; (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 6/29/26 at 0616 hours, Humalog insulin was administered to the left arm; - dated 7/1/26 at 1140 hours, Humalog insulin was administered to the left arm; - dated 7/1/26 at 1633 hours, Humalog insulin was administered to the left arm; - dated 7/1/26 at 2135 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/2/26 at 0636 hours, Humalog insulin was administered to the left arm; - dated 7/2/26 at 2135 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/3/26 at 1630 hours, Humalog insulin was administered to the left arm; - dated 7/3/26 at 2142 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/4/26 at 0549 hours, Humalog insulin was administered to the left arm; - dated 7/4/26 at 2126 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/5/26 at 2145 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/7/26 at 0725 hours, Humalog insulin was administered to the left arm; - dated 7/7/26 at 1648 hours, Humalog insulin was administered to the left arm; - dated 7/7/26 at 2104 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/8/26 at 0648 hours, Humalog insulin was administered to the left arm; - dated 7/8/26 at 2102 hours, Lantus SoloStar insulin was administered to the left arm; - dated 7/9/26 at 1247 hours, Humalog insulin was administered to the right arm; - dated 7/9/26 at 1649 hours, Humalog insulin was administered to the right arm; - dated 7/9/26 at 2100 hours, Lantus SoloStar insulin was administered to the right arm; - dated 7/10/26 at 1202 hours, Humalog insulin was administered to the left arm; - dated 7/10/26 at 1723 hours, Humalog insulin was administered to the left arm; - dated 7/11/26 at 21:33 hours, Humalog insulin was administered to the left arm; and - dated 7/11/26 at 1228 hours, Lantus SoloStar insulin was administered to the left arm. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/26 at 0828 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings and stated the insulin injection site should be rotated with each insulin administration.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary pain management care and services for six of 19 final sampled residents (Residents 4, 31, 47, 52, 62, and 91) reviewed for pain management. * The facility failed to ensure to provide nonpharmacological interventions prior administration of hydrocodone with acetaminophen (a strong prescription medication used to manage moderate to severe pain) to Residents 31. In addition, the hydrocodone with acetaminophen medication was administered when the resident's pain level did not meet the ordered parameters for severe pain. * The facility failed to ensure Resident 62 was assessed for pain and provided with nonpharmacological interventions prior to administration of the hydrocodone with acetaminophen medication. * The facility failed to administer the correct pain medication as per the physician's order for Residents 4 and 52. In addition, the facility failed to ensure the nonpharmacological pain interventions were implemented and documented prior to the medication administration. * The facility failed to ensure the nonpharmacological interventions were provided and documented prior to administration of pain medications to Residents 47, and 91. These failures had the potential to place Residents 4, 31, 47, 52, 62, and 91 at risk for ineffective pain management, increased discomfort, and potential adverse effects from unnecessary or inappropriate pain medication use. Findings: Review of the facility's P&P titled Pain Management dated 8/25/21, showed pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences is provided to residents who require such services. An individualized, interdisciplinary care plan will be developed and include addressing/ treating underlying causes of pain to the extent possible; non-pharmacological and pharmacological approaches; and using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms. Residents receiving intervention for pain will be monitored for the effectiveness and side effects (e.g., constipation, sedation) in providing pain relief. To document nonpharmacological interventions and effectiveness, effectiveness of PRN medications, ineffectiveness of routine or PRN medications including interventions, follow-up and physician notification. The care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician to report findings and obtain revised treatment orders, if indicated and to review the non-pharmacological approaches for effectiveness. 1. Medical record review for Resident 31 was initiated on 7/12/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 6/27/26, showed Resident 31 had the capacity to understand and make decisions. Review of Resident 31's Order Summary Report showed the following physician's orders: - dated 6/26/26, to document nonpharmacological interventions(s) A. Heat, B. Repositioning, C. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Relaxation breathing. D. Food/Fluid E. Massage, F. Exercise, G. Immobilization of joint, H. Other write in progress note as needed, document results of non-pharm interventions was ineffective or effective; - dated 6/26/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every four hours as needed for severe pain (scale 7-10; zero = no pain and 10 = worst); and - dated 6/28/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every four hours as needed for severe pain (scale 8-10). Review of Resident 31's MAR for June 2026 showed Resident 31 was administered the hydrocodone-acetaminophen 10-325 mg medication on the following dates, times, and pain levels: - dated 6/27/26 at 2112 hours, for a pain level of 8; without nonpharmacological interventions documented. - dated 6/30/26 at 1700 hours, for pain level of 3; without nonpharmacological interventions documented. Review of Resident 31's MAR for July 2026 showed Resident 31 administered the hydrocodone-acetaminophen 10-325 mg medication for on the following dates, times, and pain levels: - dated 7/1/26 at 0420 hours, for pain level of 9; without nonpharmacological interventions documented. - dated 7/1/26 at 1145 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/1/26 at 1716 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/1/26 at 2230 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/1/26 at 1716 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/2/26 at 2226 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/3/26 at 2243hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/4/26 at 2158 hours, for pain level of 8; without nonpharmacological interventions documented. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 7/5/26 at 2240 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/6/26 at 0944 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/6/26 at 1615 hours, for pain level of 5; without nonpharmacological interventions documented. - dated 7/8/26 at 0915 hours, for pain level of 9; without nonpharmacological interventions documented. - dated 7/8/26 at 1322 hours, for pain level of 9; without nonpharmacological interventions documented. - dated 7/8/26 at 2155 hours, for pain level of 9; without nonpharmacological interventions documented. - dated 7/9/26 at 0606 hours, for pain level of 6; without nonpharmacological interventions documented. - dated 7/9/26 at 1643 hours, for pain level of 9; without nonpharmacological interventions documented. - dated 7/10/26 at 0152 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/11/26 at 0604 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/11/26 at 2134 hours, for pain level of 8; without nonpharmacological interventions documented. - dated 7/12/26 at 0231 hours, for pain level of 8; without nonpharmacological interventions documented. On 7/13/26 at 1235 hours, an interview and concurrent medical record review for Resident 31 was conducted with LVN 4. LVN 4 stated if the nonpharmacological interventions were ineffective, then the licensed nurse would administer the PRN pain medication as per the physician's orders. LVN 4 reviewed Resident 31's medical record and verified the hydrocodone-acetaminophen 10-325 medication was not administered to Resident 31 as ordered by the physician and nonpharmacological interventions were not documented as provided prior to the administration on the medication. On 7/15/26 at 0830 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to provide and document nonpharmacological interventions prior to PRN pain (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 62 was initiated on 7/12/26. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's H&P examination dated 6/3/26, showed Resident 62 had the capacity to understand and make decisions. Review of Resident 62's Order Summary Report showed the following physician's orders: - dated 6/3/26, to document non-pharmacological interventions(s) A. Heat, B. Repositioning, C. Relaxation breathing. D. Food/Fluid E. Massage, F. Exercise, G. Immobilization of joint, H. Other write in progress note as needed, document results of non-pharm interventions was ineffective or effective. - dated 6/4/26, to administer acetaminophen extra strength 500 mg tablet by mouth every six hours as needed for mild pain (scale 1-4). - dated 6/4/26, to administer acetaminophen extra strength 1000 mg tablet by mouth every 12 hours as needed for moderate pain (scale 5-7). - dated 6/4/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every 4 hours as needed for severe pain (scale 8-10). Review of Resident 62's MAR for July 2026 showed Resident 62 was administered the hydrocodone-acetaminophen 10-325 mg medication for on the following dates and times: - dated 7/1/26 at 0447 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/1/26, at 1220 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/1/26, at 1836 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/2/26, at 0145 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/2/26, at 1000 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/3/26 at 0430 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/3/26 at 1135 hours, pain level was not assessed, and no nonpharmacological interventions documented. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented. - dated 7/3/26 at 1735 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/4/26 at 0418 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/4/26 at 1735 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/5/26 at 0450 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/5/26 at 1834 hours, pain level was not assessed prior to administration of medication. - dated 7/6/26 at 0216 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/6/26 at 1836 hours, pain level was not assessed prior to administration of medication. - dated 7/7/26 at 0252 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/7/26 at 1844 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/9/26 at 0330 hours, pain level was not assessed prior to administration of medication. - dated 7/9/26 at 2143 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/10/26 at 0513 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/10/26 at 1209 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/10/26 at 1809 hours, pain level was not assessed prior to administration of medication. - dated 7/11/26 at 0035 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/11/26 at 0935 hours, pain level was not assessed, and no nonpharmacological interventions documented. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 7/11/26 at 1826 hours, pain level was not assessed prior to administration of medication. - dated 7/12/26 at 0323 hours, pain level was not assessed, and no nonpharmacological interventions documented. - dated 7/12/26 at 1352 hours, pain level was not assessed prior to administration of medication. - dated 7/12/26 at 2133 hours, pain level was not assessed prior to administration of medication. On 7/13/26 at 1245 hours, an interview and concurrent medical record review for Resident 62 was conducted with the LVN 4. LVN 4 reviewed Resident 31's medical record and verified the hydrocodone-acetaminophen 10-325 medication was not administered per Resident 31's order and nonpharmacological interventions were not documented as provided prior to the administration on the medication. On 7/15/26 at 0854 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. a. Medical record review for Resident 52 was initiated on 7/12/26. Resident 52 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 52's H&P examination dated 1/8/26, showed Resident 52 had the capacity to understand and make medical decisions. Review of Resident 52's Order Summary Report showed the following physician's orders: - dated 2/12/24, to administer morphine sulphate extended release (pain medication) 15 mg tablet by mouth two times a day for pain management. - dated 8/16/24, to administer acetaminophen 325 mg (pain medication) two tablets by mouth every four hours and needed for mild pain (1-4). On 7/12/26 at 0951 hours, Resident 52 was observed frowning and pressing the call light. When staff entered the room and asked how they could assist, Resident 52 stated he was in pain. The staff told the resident she would inform the licensed nurse then left the room. The staff did not offer any nonpharmacological pain interventions at that time. On 7/12/26 at 0953 hours, LVN 7 entered Resident 52's room. LVN 7 asked the resident to describe the location and intensity of his pain. Resident 52 reported back pain with a pain level of 8 [on a 0&ndash;10 pain scale (0 = no pain, 10 = worst possible pain)]. LVN 7 administered two tablets of the acetaminophen 325 mg tablet. LVN 7 was not observed offering or providing any nonpharmacological pain interventions before administering the medication. On 7/12/26 at 1005 hours, an interview was conducted with LVN 7. LVN 7 was informed of the above observation. LVN 7 verified he did not provide any nonpharmacological interventions before (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering pain medication to Resident 52 and should have. b. Review of Resident 52's [DATE]/1 &ndash;7/31/26, showed an active physician's order dated 8/16/24, to administer acetaminophen 325 mg two tablets by mouth as needed for mild pain (pain level 1&ndash;4). Documentation on the MAR showed the medication was administered on 7/12/26 at 0957 hours, for a reported pain level of 8, which exceeded the parameters of the physician's order. On 7/13/26 at 1527 hours, a telephone interview was conducted with LVN 7. LVN 7 verified he administered two tablets of the acetaminophen 325 mg tablet to Resident 52 on 7/12/26 at 0957 hours, when the resident complained of pain 8 out of 10. LVN 7 verified he administered the pain medication outside the ordered parameter and did not notify the physician. c. Review of Resident 52's MAR for July 2026 showed active physician's order dated 2/12/24, to administer morphine sulphate extended release 15 mg one tablet by mouth two times a day for pain management. Documentation on the MAR showed the medication was being administered and pain level was documented on the following dates and times: - on 7/1/26 at 0900 hours, pain level of 5, and at 1700 hours, pain level of 2; - on 7/3/26 at 0900 hours, pain level of 6; - on 7/4/26 at 1700 hours, pain level of 4; - on 7/5/26 at 0900 hours, pain level of 5; - on 7/7/26 at 0900 hours, pain level of 6, and at 1700 hours, pain level of 3; - on 7/8/26 at 0900 hours, pain level of 5, and at 1700 hours, pain level of 3; - on 7/10/26 at 0900 hours, pain level of 5; - on 7/11/26 at 0900 hours, pain level of 6; and - on 7/13/26 at 1700 hours, pain level of 5. However, further review of Resident 52's medical record did not show documentation indicating whether nonpharmacological pain interventions were offered or provided when Resident 52 reported pain on the above dates and times. On 7/13/26 at 1543 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified above findings and stated she was unable to find documented evidence to show nonpharmacological interventions were provided when Resident 52 complained of pain on the above dates and times. On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged the above findings. 4. Medical record review for Resident 47 was initiated on 7/12/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination dated 7/2/26, showed Resident 47 had the capacity to participate in medical decision-making and was able to understand the nature of his medical conditions, treatment recommendations, and potential risks and benefits. Review of Resident 47's Order Summary Report for July 2026 showed the following physician's orders: - dated 7/1/26, to document nonpharmacological interventions(s) A. Heat, B. Repositioning, C. Relaxation breathing, D. Food/Fluid, E. Massage, F. Exercise, G. Immobilization of joint, H. Other: Write in progress note as needed. - dated 7/3/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every six hours as needed for severe pain (8-10). Review of Resident 47's MAR for July 2026 showed Resident 47 was administered hydrocodone-acetaminophen 10-325mg as needed on the following dates and times: - 7/3/26 at 0300 hours; - 7/4/26 at 0812 hours; - 7/6/26 at 0806 hours; - 7/7/26 at 1625 hours, and 2347 hours; - 7/8/26 at 1011 hours and 1714 hours; - 7/10/26 at 0245 hours; - 7/11/26 at 0829 hours and 2016 hours; and - 7/12/26 at 0615 hours and 2039 hours. However, further review of Resident 47's MAR and medical record failed to show documented evidence nonpharmacological interventions were offered to Resident 47 prior to administering the hydrocodone-acetaminophen 10-325 mg medication. On 7/13/26 at 1235 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the licensed nurses should provide nonpharmacological interventions for pain prior to administering the ordered pain medication, such as (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioning, relaxation techniques, heat, exercise, massage, and food and/or fluids. 5. Medical record review for Resident 91 was initiated on 7/12/26. Resident 91 was admitted to the facility on [DATE]. Review of Resident 91's H&P examination dated 6/12/26, showed Resident 91 had the capacity to participate in medical decision-making and was able to understand the nature of his medical conditions, treatment recommendations, and potential risks and benefits. Review of Resident 91's MAR for July 2026 showed Resident 91 was administered oxycodone-acetaminophen 10-325 mg (pain medication) as needed on the following dates and times: - 7/4/26 at 0407 hours, 1145 hours, and 1926 hours; - 7/5/26 at 0432 hours, 1053 hours, and 1737 hours; - 7/6/26 at 0433 hours and 1451 hours; and - 7/7/26 at 0525 hours, 1151 hours, and 1855 hours. However, further review of Resident 91's MAR and medical record failed to show documented evidence nonpharmacological interventions were offered Resident 91 prior to administering the oxycodone-acetaminophen 10-325 mg medication. On 7/13/26 at 1254 hours, an interview and concurrent medical record review for Resident 91 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the nonpharmacological interventions should be provided to assess if the interventions were effective prior to administering the pain medications. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON stated nonpharmacological interventions were provided prior to administering the pain medications to ensure the licensed nurses obtained an accurate pain level. The DON further stated if the nonpharmacological interventions were effective, the resident may not need pain medications. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 6. Medical record review for Resident 4 was initiated on 7/12/26. Resident 4 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 4's MDS 5-day PPS assessment dated [DATE], showed Resident 4 BIMS Summary Score of 13, indicating intact cognition. Review of Resident 4's Order Summary Report dated 7/14/26, showed the following physician's orders: (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 6/13/26, to administer acetaminophen 325 mg two tablets (650 mg) by mouth every four hours as needed for mild pain level of 1-4; - dated 6/13/26, to administer hydrocodone-acetaminophen 5-325 mg one tablet by mouth every six hours as needed for moderate pain level of 5-7; and - dated 6/13/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every six hours as needed for severe pain level of 8-10. Review of Resident 4's MAR for June 2026 showed the resident was administered the hydrocodone-acetaminophen 5-325 mg (moderate pain level of 5-7) medication on 6/24/26 at 0634 hours for a pain level of 8. Review of Resident 4's MAR for July 2026 showed the resident was administered the hydrocodone-acetaminophen 10-325 mg (severe pain level of 8-10) medication on 7/8/26 at 1700 hours for a pain level of 3. However, further review of Resident 4's medical record failed to show any documented evidence to show nonpharmacological interventions were provided to Resident 4 prior to the administration of the pain medication. On 7/14/26 at 1329 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 3. LVN 3 stated for the residents who reported pain, the licensed nurse would assess the resident's pain level prior to the administration of the pain medications. LVN 3 further stated the pain medication would be administered per the physician's order and within the ordered parameters. LVN 3 verified the correct pain medication was not given according to the resident's reported pain level, and there was no documentation to show non-pharmacological interventions were provided prior to medication administration. On 7/14/26 at 1355 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to accurately document the resident's pain level and administer the pain medication per the physician's order. The DON was informed and acknowledged above findings. On 7/15/26 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the cutting boards were kept in a sanitary condition, with smooth, cleanable surface. * The facility failed to ensure the toaster used to warm bread for the residents was kept in a sanitary condition. * The facility failed to ensure kitchen equipment and utensils were stored and maintained in a sanitary condition. * The facility failed to ensure proper labeling and dating of food stored in the refrigerator. These failures had the potential to result in foodborne illnesses for the 89 residents who consumed food prepared in the facility's kitchen. Findings: Review of the facility's document titled Diet Type report dated 7/12/26, showed 89 of 94 residents were receiving food prepared in the facility's kitchen. 1. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, cutting 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 foods that are prepared on such surfaces. On 7/12/26 at 0746 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with Dietary Aide 1. Three cutting boards were observed to be fuzzy and heavily marred with grooves. Dietary Aide 1 verified the findings. 2. Review of the facility's P&P titled Equipment revised 9/2017 showed all food service equipment will be clean, sanitary, and in proper working order. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-foods contact equipment will be clean and free of debris. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, Section, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 7/12/26 at 0748 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. The following was observed:- A kitchen toaster stored on a countertop shelf was dirty with dry food residue, crumbs and rust inside the toaster. - A utensil drawer contained miscellaneous items including paper and a pen. Dietary Aide 1 verified the findings and stated the items should have been cleaned for infection control purposes. 3. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-contact surface and utensils shall be clean to sight and touch. On 7/12/26 at 0748 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with Dietary Aide 1. A can opener blade with excessive wear was observed. Dietary Aide 1 verified the findings. 4. Review of the facility's P&P titled Food Storage: Cold Foods revised 2/2023 showed all food will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. On 7/12/26 at 0748 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with Dietary Aide 1. Two plates of salad stored in the refrigerator were observed without date labels. Dietary Aide 1 verified the findings, and stated food must be dated when prepared. On 7/15/26 at 0824 hours, an interview was conducted with DSS. The DSS verified (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and acknowledged the above findings. On 7/15/26 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and facility P&P review, the facility failed to maintain infection control practices. * The facility failed to ensure RN 1 performed appropriate hand hygiene during an intravenous (IV) medication administration observation. * The facility failed to ensure LVN 6 performed appropriate hand hygiene between oral and ophthalmic routes during a medication administration observation. * The facility failed to show consistent and accurate documentation of its testing protocols for Legionella and other opportunistic pathogens in building water systems for the kitchen water temperatures for February 2026. * The facility failed to ensure the staff performed appropriate hand hygiene after touching a soiled linen cart and before entering Resident 80's room to provide care. These failures placed the residents at risk for infection and disease transmission. Findings: Review of the facility's P&P titled Handwashing/Hand Hygiene dated 9/18/23, showed the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol- based hand rub containing at least 62% alcohol before and after contact with resident, after contact with blood, body fluids, visibly contaminated surface or after contact with objects in the resident room. 1. Review of the facility's P&P titled Administering Medications revised 4/2019 showed the staff follows established facility infection control procedures including handwashing and antiseptic techniques for the administration of medications, as applicable. On 7/13/26 at 0907 hours, an IV medication administration observation for Resident 62 was conducted with RN 1. RN 1 prepared Resident 62's IV medication, then donned on gloves and a gown. RN 1 was not observed performing hand hygiene prior to administering the IV medication to Resident 62. On 7/13/26 at 0923 hours, an interview was conducted with RN 1. RN 1 verified she did not perform hand hygiene before administering the IV medication administration for Resident 62 and stated she should have done so to maintain infection control protocols. 2. Review of the facility's P&P titled Specific Medication Administration Procedures: Eye Drop Administration dated 3/2019 showed to administer the ophthalmic solution into and around the eye in a safe and accurate manner. Procedures include washing your hands. On 7/13/26 at 0946 hours, a medication administration observation for Resident 39 was conducted with LVN 6. LVN 6 was observed administering Resident 39's oral medications, then ophthalmic drops without performing hand hygiene between the different medication routes. On 7/13/26 at 1001 hours, an interview was conducted with LVN 6. LVN 6 verified he did not perform hand hygiene between the oral and ophthalmic administration and stated hand hygiene should have been performed between the different routes to ensure infection control practices were maintained (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and prevent eye infections. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON stated the staff should perform hand hygiene between different medication routes and before and after medication administration to maintain infection control. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's Water Management Program (undated) showed in Section IV for control measures and monitoring for daily water temperature reading. However, there was no documented evidence to show consistent and accurate documentation of its testing protocols for Legionella and other opportunistic pathogens in building water systems for the kitchen water temperatures for the entire month of February 2026. On 7/14/26 at 1133 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director was informed and verified the above findings. On 7/14/26 at 1006 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings. 4. On 7/13/26 at 1058 hours, CNA 2 was observed touching a soiled linen cart then entering Resident 80's room and repositioning the resident's pillow without performing hand hygiene after touching soiled linen cart. On 7/13/26 at 1101 hours, an interview was conducted with CNA 2. CNA 2 was informed of the above observation. CNA 2 verified the observation and stated she forgot to perform hand hygiene after touching the soiled linen cart and before entering Resident 80's and assisting the resident. On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure a resident representative was provided for one of 19 final sampled residents (Resident 6) reviewed for resident rights. * The facility failed to ensure Resident 6, who was unable to make her own decisions, was provided with a resident representative or a public resident representative through The Office of the Long-Term Care Patient Representative (OLTCPR) as required by AFL 23-18. This failure placed Resident 6 at risk for not receiving adequate representation during care and treatment decisions. Findings: Review of the AFL 23-18 titled Interdisciplinary Team (IDT) Authorized Medical Interventions for Residents Unable to Provide Informed Consent and Without a Health Care Decision Maker dated [DATE], showed a resident representative must participate in the IDT process and decision-making for the resident on a proposed medical treatment intervention. Facilities must attempt to locate, with reasonable diligence, a person or entity willing and able to serve as a patient representative. The OLTCPR provides public patient representatives to participate in the IDT process for residents who require a medical intervention that requires informed consent in the absence of a conservator, family member, friend, or legal surrogate decision maker. The AFL further showed the IDT must oversee the care of the resident using a team approach to assessment and care planning, and must include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and a patient representative, in accordance with applicable federal and state requirements. An IDT review must not occur without the participation of a patient representative and until the notice required has been provided to the resident and patient representative. Review of the facility's P&P titled Bioethics Committee for Residents Without Capacity to Make Medical Decisions and Without a Legally-Recognized Decision-Maker (undated) showed the recommended bioethics committee members included: - Center Administrator; - Center Director of Nursing; - Center Medical Director or designee; - Community representative such as clergy, volunteers, and ombudsperson; and - Other members as appropriate. Medical record review for Resident 6 was initiated on [DATE]. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated [DATE], showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Notification and Decision Making for Incapacitated Resident dated [DATE], showed the resident was informed of the right to have a resident representative participate in the IDT decision-making process, and the right to a judicial review of IDT decisions. Review of Resident 6's Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE], showed Resident 6's legal decisionmaker was the facility's IDT. Review of Resident 6's SNF/NF to Hospital Transfer Form dated [DATE], showed the Resident Representative Notified section listed only the IDT. The document did not show Resident 6's representative or public resident representative from the OLTCPR was notified of the hospital transfer. Review of Resident 6's Interdisciplinary Care Conference - V 5 - Care Conference dated [DATE], failed to show documented evidence a resident's representative participated in the meeting. Review of Resident 6's medical records titled Interdisciplinary Care Conference - V 5 - Psychotropic Medication Management (PMM) dated [DATE], failed to show documented evidence a resident's representative participated in the meeting. Review of Resident 6's medical records titled Interdisciplinary Care Conference - V 5 - Care Conference dated [DATE], failed to show documented evidence a resident's representative participated in the meeting. On [DATE] at 1332 hours, an interview and concurrent medical record review for Resident 6 was (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the SSD. The SSD verified the above findings. The SSD stated the facility did not involve a resident's representative in Resident 6's care as required by AFL 23-18. On [DATE] at 1530 hours, a follow up interview was conducted with the SSD. The SSD stated she did not contact the OLTCPR to obtain a public resident representative for Resident 6. On [DATE] at 0930 hours, an interview was conducted with the DON. The DON verified Resident 6 could not make her own medical decisions and stated a resident's representative should be present for Resident 6's overall care. On [DATE] at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure residents and/or resident representative were provided with the right to self-determination for one of 19 final sampled residents (Resident 9). * The facility failed to ensure the informed consent for psychotropic medication buspirone (antianxiety) and escitalopram (antidepressant) for Resident 9 included the indication of use, manifested behavior, and nonpharmacological interventions that could address the behavior related to the use of the psychotropic medication. In addition, the informed consent forms for buspirone and escitalopram were not signed by the physician. Furthermore, the facility failed to ensure informed consent was obtained prior to administering the Ativan (antianxiety) medication to Resident 9. These failures placed resident at risk for not receiving adequate information to make informed decisions regarding the risks and benefits of psychotropic medications and for not being fully included in treatment decisions. Findings: Review of the AFL 25-27 titled AB 48 & Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information that the provider shall provide includes but is not limited to how the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and warning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. Review of the facility's P&P titled Informed Consent for Psychotropic Drugs (undated) showed prescriber practitioner (e.g., physician, nurse practitioner, physician assistant within scope) to obtain informed consent for all psychotropic medication prior to initiation or dose increase, document the discussion, resident/resident representative's understanding, and consent/refusal in the medical records. Prescriber practitioner to attempt and document non-pharmacological intervention before or alongside psychotropics, unless contraindicated. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 9 was initiated on 7/12/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 5/4/26, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 5/21/26, to administer escitalopram oral tablet 10 mg to by mouth one time a day for depression as manifested by verbalization of feeling sad; give with escitalopram 5 mg for a total of 15 mg daily. - dated 6/19/26, to administer buspirone HCL oral tablet 5 mg by mouth two times a day for anxiety as manifested by verbalization of feeling anxious. - dated 7/9/26, to administer Ativan oral tablet 0.5 mg to give one tablet by mouth every 12 hours as needed for 30 days for anxiety as manifested by constant screaming about having migraine headache. a. Review of Resident 9's Psychotropic Medication Administration Disclosure (Antianxiety) showed for Ativan 0.5 mg medication, to administer by mouth as needed every 12 hours for 14 days. Resident 9 was informed on 6/19/26. However, further review of Resident 9's medical record failed to show if the informed consent was obtained when the Ativan 0.5 mg was ordered with extended duration (i.e. 30 days) on 7/9/26. Review of Resident 9's MAR dated 7/1-7/31/26 showed a physician's order dated 7/9/26, to administer Ativan oral tablet 0.5 mg to one tablet by mouth every 12 hours as needed for 30 days for anxiety as manifested by constant screaming about having migraine headache. Further review of the MAR showed Resident 9 had received the medication on 7/9, 7/10, 7/11, 7/12, and 7/13/26. b. Review of Resident 9's Psychotropic Medication Administration Disclosure (Antianxiety) showed for buspirone 5 mg, to administer by mouth two times a day. Resident 9 was informed on 6/19/26. However, further review of the form failed to show the indications, manifested behavior, and the list of possible nonpharmacological approaches that could address the resident's behavior related to the use of buspirone medication. In addition, the form did not show a physician's signature. c. Review of Resident 9's Psychotropic Medication Administration Disclosure (Anti- Depressant) for escitalopram 15 mg, showed Resident 9 was informed on 5/2/26. However, further review of the form failed to show the indications, manifested behavior, and the list of possible non-pharmacological approaches that could address the resident's behavior related to the use of escitalopram medication. In addition, the form did not show a physician's signature. On 7/13/26 at 1129 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 1. RN 1 verified the physician's orders for Ativan, buspirone, and escitalopram for Resident 9. RN 1 stated the informed consent for Ativan 0.5 mg was obtained when it was ordered on 6/19/26 for 14 days. RN 1 verified the physician renewed the order for Ativan 0.5 mg to administer as (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed with extended duration for 30 days on 7/9/26; however. RN 1 was unable to find the documentation showing the informed consent was obtained when Ativan 0.5 mg was ordered on 7/9/26 for 30 days. RN 1 verified Resident 9's Psychotropic Medication Administration Disclosure (Antianxiety) for the buspirone 5 mg medication for Resident 9 did not show the indication, manifested behavior, and the list of possible nonpharmacological approaches that could address the resident's behavior related to the use of buspirone medication. RN 1 also verified the form did not show a physician's signature. RN 1 was unable to find documentation showing if the physician documented the discussion, Resident 9's understanding, and consent/refusal related to buspirone 5 mg in the resident's medical record. RN 1 verified Resident 9's Psychotropic Medication Administration Disclosure (Antidepressant) for the escitalopram 15 mg medication did not show the indication, manifested behavior, and the list of possible nonpharmacological approaches that could address the resident's behavior related to the use of the escitalopram medication. RN 1 also verified the form did not show a physician signature. RN 1 was unable to find documentation showing if the physician documented the discussion, Resident 9's understanding, and consent/refusal related to escitalopram 15 mg in the resident's medical record On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were safely administered for one of 94 residents (Resident 105). * Resident 105 had Visine Red Eye Hydrating Comfort eye drops (reduces redness of the eyes) on the nightstand beside the resident. This failure had the potential for the resident to inaccurately self-administer the medications, develop adverse reactions, and negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications revised February 2022 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Upon the request of the resident, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. On 7/12/26 at 0828 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 105. Resident 105 was observed lying in bed and a Visine Red Eye Hydrating Comfort eye drop bottle was observed on the nightstand beside the resident. Resident 105 stated he instilled the eye drops himself. Review of Resident 105's Order Summary Report dated 7/13/26, failed to show the physician's order for the Visine Red Eye Hydrating Comfort eye drops and/or for Resident 105 to self-administer medications. Further review of Resident 105's medical record failed to show the resident was assessed to determine if the resident was clinically appropriate and safe to self-administer medications. On 7/12/26 at 0832 hours, an observation, interview and concurrent medical record review for Resident 105 was conducted with LVN 4. LVN 4 verified the eye drops bottle was on Resident 5's nightstand. LVN 4 further verified Resident 105 had no physician's order for the Visine Red Eye Hydrating Comfort eye drops, and/or for to self-administer medications. On 7/15/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 9) reviewed for the unnecessary medications was free from the unnecessary psychotropic medications. * The facility failed to ensure the PRN psychotropic medication ordered for Resident 9 was limited to 14 days as required. The physician did not provide documentation justifying the continued use of the PRN psychotropic medication beyond 14 days when Ativan (antianxiety) 0.5 mg was ordered PRN for 30 days. This failure had the potential to place Resident 9 at risk for adverse drug effects, inappropriate medication use, and a decline in their overall health and well-being. Findings: Review of the facility P&P titled Psychotropic Medication Use dated 6/2021 showed psychotropic medication to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical records. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Medical record review for Resident 9 was initiated on 7/12/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 5/4/26, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed a physician's order dated 7/9/26, for Ativan 0.5 mg one tablet by mouth every 12 hours PRN for 30 days for anxiety as manifested by constant screaming about having migraine headache. However, further review of the Resident 9's medical records failed to show documentation from the physician providing the justification for the use of the PRN Ativan medication beyond 14 days. On 7/13/26 at 1129 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN^1. RN^1 verified the physician's order for Ativan 0.5 mg to be administered PRN for 30 days for anxiety, as manifested by constant screaming about having migraine headaches. RN^1 stated she was unable to locate any documentation in the resident's medical record indicating the physician provided the required clinical justification for extending the PRN psychotropic medication beyond the 14 day regulatory limit. On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure a safe and effective transition of care when a resident was transferred to the acute care hospital for one of three residents (Resident 102) reviewed for closed records. * The facility failed to ensure for a documented evidence the required information was communicated to the receiving provider, including contact information of the practitioner responsible for the resident's care, resident's representative information, advance directive information, and any special instructions or precautions for ongoing care, as appropriate. This failure had the potential to result in incomplete or delayed care, miscommunication of the resident's medical needs, and an increased risk of adverse outcomes during the transition to the acute care hospital. Findings: Review of the facility's P&P titled Transfer or Discharge (undated) showed when the facility transfer or discharges a resident, the following information documented in the medical record and appropriate information is communicated to the receiving health care institution or provider which included a summary of the resident's overall medical, physical, and mental condition. Closed medical record for Resident 102 was initiated on 7/14/26. Resident 102 was admitted to the facility on [DATE], and transferred to the acute care hospital on 6/2/26. Review of Resident 102's Order Summary Report, showed a physician's order dated 6/2/26, to transfer Resident 102 to the acute care hospital via 911 for respiratory distress. Review of Resident 102's SNF/NF to Hospital Transfer Form showed the resident was transferred to an acute care hospital on 6/2/26. The section for code status was left blank. The Acute Care Transfer Document Checklist for Resident 102 included a list of documents recommended or required to accompany the resident, such as the transfer form, face sheet, current medication list or MAR, SBAR/change in condition note, advance directives, advance care orders, and additional medical records (history and physical, recent discharge summary, lab results, diagnostic tests, and specialist orders). However, review of the checklist showed no entries or check marks, indicating no documentation of what information or records were sent with the resident. Additionally, the section designated for EMT and transport team signatures was also blank. Further review of Resident 102's medical record did not show any documentation if the required information, including the practitioner's contact details, resident's representative information, advance directive information, and special instructions or precautions for ongoing care was communicated to the receiving provider. On 7/14/26 at 1018 hours, an interview and concurrent closed medical record review for Resident 102 was conducted with RN 1. RN 1 verified Resident 102 was transferred to the acute care hospital on 6/2/26 via 911, and stated she was unable to find the documented evidence to show the required information had been communicated to the receiving provider. On 7/15/26 at 0901 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the recommendations from the PASRR Level II determination were incorporated into the resident's care for one of two final sampled residents (Resident 5) reviewed for PASRR. * The facility failed to incorporate the Level II PASRR recommendations into the assessment and care planning for Resident 5. This failure had the potential to result in Resident 5 not receiving adequate care as recommended by the PASRR Level II determination conducted by the state-designated authority. Findings: Medical record review for Resident 5 was initiated on 7/12/26. Resident 5 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 5/4/26, showed Resident 5 lacked medical decision-making capacity due to advanced dementia and cognitive impairment. Review of Resident 5's PASRR Notice of Individual Determination dated 5/6/26, showed a Serious Mental Illness (SMI) Level II documentation of the resident's medical and social history, which revealed a significant medical condition with mental stressors that required nursing care. The following specialized add-on services (services and support that supplement nursing facility care to address mental health needs) were recommended:- Mental Health Rehabilitation Activities These include therapeutic community, dance, music, art, exercise, leisure, recreation, orientation, education, and/or skill building activities.- Activities of Daily Living (ADL) Training/Reinforcement Skill training and support to improve day-to-day activities such as dressing, bathing, feeding, toileting, and grooming.- Supportive Services Interactions with facility staff that encourage problem solving, socialization, reality orientation or focus on therapeutic goals.- Psychotherapy/Counseling Individual and/or group and/or family treatment provided by a licensed mental health professional. Therapy may include a combination of strategies and techniques such as supportive, cognitive behavioral, psychodynamic, art/music, counseling, skills training, and existential therapies, among others.- Psychiatry Consultation and/or Follow-up Care Services to provide psychopharmacological intervention and monitoring of mental conditions. These providers will evaluate the efficacy and necessity of psychiatric medications, review lab profiles, make adjustments as needed, and address side effects.- Safety Monitors Safety monitors for risk of falling and harm to others.- Behavior Monitors Behavior Monitors for physical aggression and verbal aggression. Additional Functional/Medical Recommendations included:- Pharmacy Consultation Services to review pharmacological issues, such as drug interactions and black box warnings.- Physical Therapy Consultation Services to enhance and restore functional ability and quality of life to those with physical impairments.- Occupational Therapy Consultation Services to improve independence in activities of daily living.- Speech Therapy Consultation Services to address impairment of speech, voice, language, communication, and swallowing.- Dietary Consultation Services to manage weight and/or special nutritional needs.- Social Services Consultation Services to discuss goals and coordinate care. Social workers can also arrange safe and orderly transitions to alternative levels of care when appropriate and facilitate communication with other caregivers. Alternative Community Placement Settings and Features included:- Accessibility Accommodations Accessibility accommodations address physical, sight, hearing, and/or communication impairment and must be provided in any alternative placement. A facility should provide bed rails, shower bars, walker access and wheelchair access. However, review of Resident 5's plan of care dated 5/6/26, failed to show an individualized care plan incorporating the PASRR Level II recommendations. On 7/13/26 at 0917 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours, an interview and concurrent medical record review for Resident 5 was conducted with the MDS Coordinator. The MDS Coordinator was unable to show an individualized care plan reflecting the PASRR Level II recommendations from the DHCS psychologist. On 7/15/26 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services related to GT feeding for one of three residents (nonsampled Resident 48) reviewed for tube feedings. * The facility failed to ensure Residents 48 received the complete dose of the GT enteral feeding as ordered by the physician. This failure had the potential to result in unmet nutritional needs and place Resident 48 nutritional at risk for adverse outcomes, including weight loss and/or dehydration. Findings: Review of the facility's P&P titled Enteral Feeding - Safety Precautions revised 4/2026 showed all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in their responsibilities. The facility will remain current in and follow accepted best practice in enteral nutrition. Medical record review for Resident 48 was initiated on 7/12/26. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's H&P examination dated 3/18/26, showed Resident 48 lacked the capacity to make independent medical decisions. Review of Resident 48's MDS quarterly assessment dated [DATE], showed Resident 48 had a feeding tube and a diagnosis of dysphagia (difficulty swallowing). Review of Resident 48's Order Summary Report showed a physician's order dated 4/7/26, to administer Glucerna 1.2 (enteral feeding formula) at 45 ml/hr for 20 hours (on at 1200 hours, off at 0800 hours or when dose completed) to provide 900 ml/1080 kcal. On 7/12/26 at 0826 hours, during the initial tour of the facility, Resident 48 was observed in bed with a bag of Glucerna 1.2 hanging on the pole. The feeding pump was observed in the off position. On 7/12/26 at 0941 hours, an observation and concurrent interview for Resident 48 was conducted with LVN 1. Resident 48 was observed in bed with Glucerna 1.2 enteral feeding hanging. LVN 1 verified Resident 48's enteral pump was off. Upon checking the GT feeding pump, the pump displayed feeding incomplete. The pump feeding history showed 206 ml left. LVN 1 verified Resident 48 did not receive the prescribed 900 ml dose of enteral feeding. On 7/14/26 at 1355 hours, an interview was conducted with the DON. The DON stated the licensed nurses are expected to ensure the residents receiving enteral feeding received the full amount prescribed by the physician. The DON further stated failure to provide the full amount increased the risk of adverse outcomes, including weight loss. On 7/15/26 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 109) reviewed for IV therapy was properly monitored. * The facility failed to ensure Resident 109's midline catheter to the right upper arm was measured upon admission and after dressing changes, as per the facility's P&P. This failure had the potential to result in inadequate monitoring and care for Resident 109, who was receiving IV medications. Findings: Review of the facility's P&P titled IV Midline Catheter Dressing Change dated 3/2023 showed the midline catheter dressing change procedure is to be performed by a RN and IV Certified LVN according to state law and facility policy. Measure upper arm circumference (three inches or 10 cm above insertion site): 1. Upon admission; and 2. Measure upper arm circumference when clinically indicated to assess the presence of edema (swelling) and possible deep vein thrombosis (blood clot). The P&P further showed documentation in the medical record includes, but is not limited to: 1. Date and time; 2. Site assessment; 3. Length of external catheter; 4. Upper arm circumference; 5. Resident response to procedure and/or medication; and 6. Resident teaching. Medical record review for Resident 109 was initiated on 7/12/26. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's MDS admission assessment dated [DATE], showed Resident 109 had a BIMS score of 14, indicating intact cognition. Review of Resident 109's medical record (untitled) dated 7/6/26, showed the resident had a single-lumen midline catheter to the right brachial vein (deep blood vessel in the upper arm that carries oxygen-depleted blood back to the heart) inserted in the acute care hospital on 7/6/26. Review of Resident 109's Order Summary Report for July 2026 showed the following physician's orders: - dated 7/6/26, to administer ceftriaxone sodium (broad spectrum antibiotic) IV solution one gram daily for cellulitis (bacterial skin infection) to both lower extremities until 7/18/16. - dated 7/7/26, for IV: Change Catheter Site Transparent Dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital). Notify the practitioner if the external length has changed since last measurement every day shift on Saturday. - dated 7/12/26, for IV: Change Catheter Site Transparent Dressing. Check external catheter length and arm circumference every dressing change every day shift weekly on Saturday. However, further review of Resident 109's medical record failed to show documented evidence Resident 109's midline external catheter and arm circumference were measured upon admission and after each dressing change. On 7/15/26 at 0833 hours, an observation, interview, and concurrent medical record review for Resident 109 was conducted with RN 1. Resident 109's midline catheter dressing was dated 7/11/26. RN 1 verified there was no documentation of the external catheter length or arm circumference measurement on admission or after the dressing change on 7/11/26. RN 1 stated the midline catheter and arm circumference should be measured and documented to assess placement. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to measure the midline catheter length and arm circumference to ensure the midline was not dislodged and remained correctly placed. The DON further stated the midline catheter length, and arm circumference should be assessed upon admission and during dressing changes. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record, and facility P&P review, the facility failed to ensure the appropriate respiratory care was provided for one of one final sampled resident (Resident 40) reviewed for respiratory care and one nonsampled resident (Resident 74). * The facility failed to ensure Resident 40's CPAP humidifier, and filter were cleaned weekly; mask, nasal pillow and tubing were cleaned daily, and headgear (strap) was washed as needed, as per facility policy. * The facility failed to ensure Resident 74's BiPAP humidifier and filter were cleaned weekly; mask, nasal pillow and tubing were cleaned daily, and headgear (strap) was washed as needed, as per facility policy. In addition, the facility failed to ensure Resident 74's oxygen nasal cannula was properly stored in a bag when not in use. These failures had the potential to affect the respiratory health and well-being of the residents. Findings: Review of the facility's P&P titled CPAP (Continuous Positive Airway Pressure, a machine treats obstructive sleep apnea by gently blowing pressurized air through a tube and mask into a person's airway)/ BiPAP (Bilevel Positive Airway Pressure, is a non-invasive ventilator used to help people breathe more easily). Support and Cleaning revised March 2015 showed in general guidelines for cleaning: Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed; Humidifier (if used): a. Use clean, distilled water only in the humidifier chamber. b. Clean humidifier weekly and air dry. c. To disinfect, place vinegar-water solution (1 :3) in clean humidifier. Soak for 30 minutes and rinse thoroughly; Filter cleaning: a. Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. b. Replace disposable filters monthly; Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses; and Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. 1. On 7/12/26 at 1005 hours, during the initial tour of the facility, Resident 40 was observed in his room lying in bed. A CPAP machine was observed on the nightstand. Resident 40 stated he used the CPAP every night and the staff had never cleaned the humidifier, headgear, tubing or mask. Medical record review for Resident 40 was initiated on 7/12/26. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's MDS assessment dated [DATE], showed Resident 40 had a BIMS score of 15, indicating intact cognitive capacity. Review of Resident 40's Order Summary Report showed a physician's order dated 3/23/26, to turn CPAP on at bedtime and off in the morning. Further review of Resident 40's medical record failed to show documentation that the CPAP equipment was cleaned as per the facility protocol. On 7/15/26 at 0810 hours, an interview was conducted with the DON. The DON stated the CPAP/ BiPAP equipment should have been cleaned according to the facility policy. The DON was informed and acknowledged the above findings. 2. On 7/12/26 at 0847 hours, during the initial tour of the facility, Resident 74 was observed lying on her bed using BiPAP. The resident's oxygen nasal cannula was observed placed underneath the pillow. Medical record review for Resident 74 was initiated on 7/12/26. Resident 74 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 74's H&P examination dated 4/14/26, showed Resident 74 had capacity to understand and make decisions. Review of Resident 74's Order Summary Report showed the following physician's orders:- dated 7/9/26, to administer the oxygen via nasal cannula at two liters per minute as needed to maintain the oxygen saturation at 92% or for shortness of breath. - dated 7/12/26, to turn BiPAP on every shift as needed. a. On 7/14/26 at 1120 hours, an interview was conducted with Resident 74. Resident 74 stated the staff had never cleaned the BiPAP humidifier, headgear, tubing or mask. Review of (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 74's medical record failed to show documentation that the BiPAP equipment was cleaned as per the facility protocol. On 7/15/26 at 0800 hours, an interview was conducted with LVN 2 for Residents 40 and 74. LVN 2 stated the RN filled the humidifier water for the CPAP/ BiPAP and cleaned the container only when visibly soiled. On 7/15/26 at 0810 hours, an interview and concurrent medical record review for Residents 40 and 74 was conducted with the IP. The IP stated she conducted spot checks on the CPAP/ BiPAP if it needed cleaning. The IP stated there should be a physician's order for the cleaning of the CPAP/ BiPAP humidifier, headgear, tubing or mask. The IP verified there was no physician's order for cleaning the CPAP/BiPAP humidifier, headgear, tubing or mask for Residents 40 and 74. b. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection revised November 2011 showed to keep the oxygen cannula and tubing used as needed in a plastic bag or when not in use. On 7/12/26 at 1002 hours, a follow up observation of Resident 74 and concurrent interview was conducted with the IP. The IP verified Resident 74's oxygen nasal cannula was observed placed underneath the resident's pillow. The IP stated the nasal cannula should be stored in a bag when not in use. On 7/15/26 at 0846 hours, an interview was conducted with the DON for Resident 74. The DON stated the CPAP/ BiPAP equipment should have been cleaned according to the facility policy. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were safely provided for one of seven residents (Resident 62) observed during the medication administration. * The facility failed to ensure RN 1 performed safe intravenous (IV) medication techniques when RN 1 flushed Resident 62's PICC line without removing an air bubble from the normal saline flush syringe. * The facility failed to ensure Resident 62's physician's order for the IV vancomycin (antibiotic) 1 gram/200 ml matched the IV vancomycin 1 gram/250 ml dispensed by the pharmacy. These failures posed a risk for negative health outcomes and compromised the safe delivery of IV therapy for Resident 62. Findings: Review of the facility's P&P titled Administering Medication revised 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 62 was initiated on 7/12/26. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's H&P examination dated 6/3/26, showed Resident 62 had the capacity to understand and make decisions. Review of Resident 62's Order Summary Report for July 2026 showed the following physician's orders:- dated 6/15/26, for Central line flush order: Flush PICC line with 10 ml NS before and after medication administration every 12 hours. - dated 7/6/26, to administer vancomycin HCL (antibiotic) intravenous solution 1000 mg/200 ml, use one gram intravenously every 12 hours for both lower extremity cellulitis On 7/13/26 at 0907 hours, an IV medication administration observation for Resident 62 was conducted with RN 1. RN 1 was observed flushing Resident 62's right upper arm PICC line without removing the air bubble in the NS flush syringe. In addition, RN 1 was observed administering the IV vancomycin 1 gram/250 ml to Resident 62's right upper arm. On 7/13/26 at 0923 hours, an interview was conducted with RN 1. RN 1 stated she forgot to remove the air bubble in the NS flush syringe prior to flushing Resident 62's PICC line and acknowledged that air entering a central line could cause an embolus, leading to respiratory or cardiac arrest. On 7/14/26 at 1040 hours, a telephone interview was conducted with IV Pharmacist 1 from the facility's contracted pharmacy. IV Pharmacists 1 stated the air bubble in the NS flushes should be removed prior to flushing an IV/ PICC line. When asked about the IV vancomycin dispensed for Resident 62, IV Pharmacist 1 stated the pharmacy did not dispense vancomycin 1 gram in 200 ml normal saline bags. IV Pharmacist 1 stated the flow rate of a vancomycin 1 gram/200 ml IV bag would be different from the flow rate of a vancomycin 1 gram/250 ml. IV Pharmacist 1 stated the facility should have clarified the physician's order. On 7/14/26 at 1103 hours, an interview and concurrent medical record review for Resident 62 was conducted with RN 1. RN 1 verified the IV vancomycin the facility had on hand did not match the physician's order. RN 1 stated the facility should have clarified the physician's order with the prescriber to match the vancomycin 1 gram/250 mg the facility had on hand. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated air bubbles should be removed from the NS flush and prior to flushing the IV line to prevent an embolus. The DON stated the licensed nurses were expected to check the physician's orders, to compare and match with the medication on hand prior to medication administration. The DON further stated Resident 62's IV vancomycin order should have been clarified if the physician's order and medication available did not match. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and facility P&P review, the facility failed to store the disposed drugs and biologicals in a safe manner. * The facility failed to ensure the medications placed in the medication disposal bin in Medication Room A were properly destroyed and disposed medication tablets were not left whole. This failure posed a risk for medication diversion. Findings: Review of the facility's P&P titled Medication Storage in the Facility: Storage of Medications revised 1/2025 showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. 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 recorded from the pharmacy if a current order exists. On 7/14/26 at 0928 hours, an observation and concurrent interview was conducted in Medication Room A with the DSD. Multiple whole, unidentified tablets were observed inside the biohazard container. The DSD verified the findings and stated the disposed medication tablets should have been diluted and watered down after being placed in the biohazard container to prevent inappropriate retrieval or use. On 7/15/26 at 0930 hours, an interview was conducted with the DON. The DON stated the disposed medications placed in biohazard container for destruction should be diluted in water to ensure the whole medication tablets could not be taken. On 7/15/26 at 1130 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 19 final sampled residents (Resident 31) was complete and accurately documented. * The facility failed to ensure Resident 31's blood pressure access site was accurately documented in the resident's medical record. This failure had the potential to result in the resident's care needs not being met due to inaccurate medical information. Findings: Review of the facility's P&P titled Dialysis Care dated 8/25/21, showed the blood pressure will not be taken on the arm with the shunt. Medical record review for Resident 31 was initiated on 7/12/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 6/27/26, showed Resident 31 had the capacity to understand and make decisions. Review of Resident 31's Order Summary Report showed a physician's order dated 6/26/26, indicating no blood pressure on the right arm. Review of Resident 31's plan of care showed a care plan problem dated 6/28/26, addressing the resident's risk for impaired renal function related to hemodialysis and renal insufficiency. The interventions included not to draw blood or take blood pressure on the right arm. Review of Resident 31's documented blood pressure readings for June and July 2026 showed the following readings documented on the right arm:- on 6/28/26 at 1331 hours, a blood pressure reading of 134/84 mmHg;- on 6/29/26 at 0720 hours, a blood pressure reading of 100/80 mmHg;- on 6/29/26 at 0915 hours, a blood pressure reading of 120/80 mmHg;- on 6/30/26 at 2110 hours, a blood pressure reading of 128/75 mmHg;- on 7/4/26 at 1359 hours, a blood pressure reading of 108/56 mmHg;- on 7/5/26 at 1340 hours, a blood pressure reading of 126/78 mmHg;- on 7/6/26 at 2215 hours, a blood pressure reading of 130/86 mmHg;- on 7/10/26 at 0600 hours, a blood pressure reading of 120/70 mmHg; and- on 7/12/26 at 1316 hours, a blood pressure reading of 122/66 mmHg. On 7/12/26 at 0841 hours, during the initial tour of the facility, Resident 31 was observed awake, sitting in a wheelchair with an AV shunt in the right arm. Resident 31 stated she went to dialysis every Monday, Tuesday, Thursday, and Saturday. On 7/13/26 at 0923, a follow up interview was conducted with Resident 31. Resident 31 stated the licensed nurses were not allowed to take her blood pressure on the right arm and verified blood pressure was never taken from the right arm. On 7/13/26 at 1415 hours, an interview and concurrent medical record review for Resident 31 was conducted with LVN 4. LVN 4 verified the blood pressures were not taken on Resident 31's right arm and the medical record documentation for June and July 2026 was inaccurate. LVN 4 stated taking the blood pressure on the access site would increase the resident's risk for infection and blood clot in the right AV shunt. On 7/15/26 at 0825 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 141 South Knott Avenue Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the glucometer on Medication Cart A was calibrated and the quality control testing was performed. * The facility failed to ensure the glucometer for Medication Cart A was calibrated and the quality control testing was performed daily in [DATE]. This failure had the potential for the residents requiring blood glucose checks to have inaccurate readings. Findings: Review of the facility's document titled Control Solution Testing EvenCare G2 undated, showed the purpose of the control solution testing is to make sure the EvenCare G2 Meter and the EvenCare G2 test strips are working properly. Control solution test results will be stored in meter memory and indicated by cti icon. The facility document further showed if the control solution result is out of range (too high or too low), it may be caused by the following:- Wrong brand of control solution being used;- Control solution not at room temperature;- Expired or contaminated control solution or damaged test strip; and- Meter malfunction. Review of the facility's monitoring log titled EvenCare G2 Quality Control Log for [DATE] showed the EvenCare G2 glucometer was monitored daily except on the following dates: 7/2, 7/7, 7/11, 7/12, and [DATE]. On [DATE] at 1530 hours, an interview and concurrent facility document review was conducted with LVN 5. LVN 5 verified the glucometer failed to show documented evidence it was calibrated and the quality control test for the low and high control solutions were performed. LVN 5 stated glucometers should be calibrated and quality control test should be performed to ensure the glucometers will provide accurate blood glucose readings for the residents. On [DATE] at 0930 hours, an interview was conducted with the DON. The DON stated she expects the nurses to calibrate and perform quality control checks for glucometers to ensure the facility has accurate readings of blood glucose results and to provide appropriate doses of insulin (medication used to manage blood glucose levels) as ordered. On [DATE] at 1130 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings.		