

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Palm Terrace Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11162 Palm Terrace Lane Riverside, CA 92505	
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 - Few	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 and record review, the facility failed to ensure the physician was notified when the blood sugar (BS) was above 250 mg/dl (milligram/deciliter - unit of measurement) according to the physician's order, for one of three residents reviewed (Resident 3). This failure had the potential for Resident 3's blood sugar to be uncontrolled and could result to complications. Findings: On July 10, 2026, at 11:21 a.m., an unannounced visit to the facility was conducted to investigate quality-of-care issues. On July 13, 2026, Resident 3's record was reviewed. Resident 3's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (DM - abnormal blood sugar). A review of Resident 3's Order Recap Report, included a physician's order, dated May 15, 2025, which indicated, .FINGERSTICK BLOOD SUGAR CHECK BID (twice a day). CALL MD (medical doctor) IF BG (blood glucose) GREATER THAN 250 OR LESS THAN 70 . A review of Resident 3's Medication Administration Record, for the month of May 2025, indicated Resident 3's blood sugar was above 250 mg/dl on the following dates and times: -May 27, 2025, at 4:30 p.m. 251 mg/dl; and -May 28, 2026, at 6:30 a.m.; 284 mg/dl. Further review of Resident 3's record indicated the physician was not notified of the blood sugar above 250 mg/dl on the above dates. On July 13, 2026, at 10:30 a.m., a concurrent interview of review of Resident 3's record was conducted with the Director of Nursing (DON). the DON stated when a resident is admitted to the facility and has diagnosis of DM with no diabetic medications, the facility would initiate an order to check the BS twice a day and refer to the physician if the BS is below 70 mg/dl or above 250 mg/dl. The DON stated Resident 3's BS was above 250 mg/dl on May 27 and 28, 2025. The DON stated the physician was not notified when Resident 3's BS was above 250 mg/dl. The DON stated the physician should have been notified of the BS above 250 according to the physician's order. A review of the facility's undated policy and procedure titled, Diabetes Management in the Post-Acute and Long-Term Care Setting, indicated, .When to Call the Practitioner .A systematic facility approach to diabetes management can streamline day-to-day care and reduce the frequency of episodes of hypoglycemia (low blood sugar), hyperglycemia (high blood sugar), and other acute metabolic complications .Facility may consider implementing the following .Standing orders for BGM (blood glucose monitoring) and practitioner notification that are approved by the primary care practitioner when the patient is admitted .The practitioner should be called as soon as possible when .The patient has 2 (two) or more blood glucose readings higher than 250 mg/dl (milligram/deciliter - unit of measurement) within a 24-hour period if this is accompanied by a new medical problem or a change in condition or functional status and the patient's treatment has not already been initiated or modified .		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555365	Facility ID: 555365 If continuation sheet Page 1 of 5

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure wound and care and management for pressure injuries (PI - (localized damage to the skin and underlying tissue, caused by prolonged, intense pressure, friction, or shear forces that cut off blood supply to vulnerable areas, typically over bony prominences like the heels, tailbone, and hips) were provided, for two of three residents reviewed (Residents 1 and 2), when: 1.For Resident 2, there was no complete wound assessment conducted when the resident was readmitted back to the facility; and 2.For Resident 1, there was no complete wound assessment conducted on October 22, 2025. In addition, the wound physician (WP)'s treatment recommendation was not carried out as ordered. These failures had the potential for the delay in the care and treatment of the residents' wound, and could affect overall health condition. Findings: On July 10, 2026, at 11:21 a.m., an unannounced visit to the facility was conducted to investigate quality-of-care issues. On July 10, 2026, at 11:34 a.m., during an interview conducted with the Director of Nursing (DON), the DON stated the Treatment Nurse (TXN) works Monday to Fridays and completes wound assessments on admission and weekly thereafter, conducts rounds with the wound consultants (physician or nurse practitioner) weekly and carries out treatment recommendations from the wound consultants. On July 10, 2026, at 12 p.m., during an interview conducted with the TXN, the TXN stated the following: -She would conduct wound assessments on admission and weekly thereafter; -She does rounds with the wound consultants and carry out their recommendations after the rounds; -The wound physician (WP) would come every Wednesdays and looks at major wounds such as pressure injuries (localized damage to the skin and underlying tissue, caused by prolonged, intense pressure, friction, or shear forces that cut off blood supply to vulnerable areas, typically over bony prominences like the heels, tailbone, and hips), diabetic and venous ulcers (open skin sores on the lower limbs caused by different chronic medical conditions); -During the rounds with the WP, she would document in a facility document spreadsheet titled Skin Summary, wound assessments and treatment recommendations; -The Wound Nurse Practitioner (WNP) sees the residents approved by the medical group every Tuesdays, documents the assessments in the residents' electronic health record within 24 hours from visit. The TXN provided a list of current residents with skin breakdown and type of wound present and currently being treated. 1.On July 10, 2026, at 12:37 p.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was observe lying on a low air loss mattress (a specialized medical mattress featuring microscopic holes that continuously release a gentle stream of air) in bed with head of bed elevated. Present in the room were two family members visiting the resident. In a concurrent interview with Resident 2, she stated, she had been in the facility for about four (4) months for wound management on her buttocks. Resident 2's family member (FM) stated Resident 2 has a pressure wound on from the buttocks to the tailbone, with bone exposure. Resident 2's FM stated the resident was recently readmitted from general acute care hospital (GACH) on July 7, 2026, for continuation of wound management. On July 10, 2026, during a review of Resident 2's record indicated the following: -Initially admitted to the facility on [DATE]; was transferred to GACH on June 27, 2026, and readmitted back to the facility on July 7, 2026, with diagnoses which included quadriplegia (he partial or total loss of motor and sensory function in all four limbs (both arms and legs) and the torso), and osteomyelitis (a painful infection in the bone that causes inflammation, bone damage, and pus buildup); -Minimum Data Set (MDS - a resident assessment tool), dated May 21, 2026, indicated a BIMS (Brief Interview of Mental Status) score of 15, which indicated cognitively intact. The MDS also (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 2 is totally dependent on most ADLs (Activities of Daily Living); -Treatment order to Stage 4 PI (a severe wound defined as full-thickness skin and tissue loss with directly exposed or palpable fascia [sheets of connective tissue], muscle, tendon [a tough, fibrous cord of connective tissue that firmly attaches muscle to bone] , ligament [a tough, fibrous band of connective tissue in the body that connects bones to other bones or holds organs in place], cartilage [a strong, flexible type of connective tissue that cushions joints, supports body structures, and acts as a shock absorber], or bone) wound on left ischium (the lower and back part of the hip bone); -Progress Notes, dated July 7, 2026, at 6:20 p.m., indicated, .admitted an (resident's age) female from (name of GACH) arrived at 1820 (6:20 p.m.) .Skin assessment done and noted .OPEN WOUND TO BUTTOCK AREA . _Progress Notes, dated July 7, 2026, at 10:06 p.m., documented by the TXN, indicated, .Skin issue .Location: Buttocks - generalized .extending to bilateral upper posterior thighs .PT (patient) NEW ADMIT TO FACILITY .NOTED WITH STAGE 4 PRESSURE ULCER TO LEFT ISCHIAM WOUND TO ISCHIAM NOTED WITH HEAVY SEROPURULENT (a fluid that consists of a mixture of serum and pus) DRAINAGE . -Further review of Resident 2's record indicated there was no complete wound assessment of the stage 4 on the left ischium which included the size of the wound. On July 10, 2026, at 1:55 p.m., during a concurrent interview and review of Resident 2's record conducted with the TXN, the TXN stated Resident 2 was readmitted the night of July 7, 2026. The TXN she conducted wound assessment but failed to include in her documentation the size of the stage 4 wound on the left ischium. The TXN stated there should have been a completed wound assessment which includes the size of the wound to have baseline to see if the wound is improving or worsening. The TXN stated she missed to get the size of the wound. On July 10, 2026, at 3:10 p.m., during a concurrent interview and review of Resident 2's record with the DON, the DON stated a complete wound assessment includes location of the wound, size, wound bed description, and wound drainage. The DON stated it is important to conduct and document a complete wound assessment to have a baseline when it is reassessed if the wound is improving or worsening. 2. On July 10, 2026, during a review of Resident 1's record indicated the following: -The Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included left femur (the longest, heaviest, and strongest bone in the human body, commonly known as the thighbone) fracture (break), generalized muscle weakness, and difficulty walking; -Progress Notes, dated October 8, 2025, at 10 p.m., indicated, .Clinical admission .Coccyx (the small, triangular bone located at the very base of your spine, just below the sacrum) .DTI (Deep Tissue Injury - a type of pressure injury which has damage to deep soft tissues beneath the skin, caused by long periods of pressure or sliding force (shear) appearing like a purple or dark red localized area of intact skin, or a small blood-filled blister) Wound was present on admission . -Physician's order, dated October 9, 2025, indicated, ,,,TX (treatment) COCCYX: CLEANSE WITH NS (normal saline), PAT DRY, APPLY MEDIHONEY AND COVER WITH FOAM DRESSING every day shift for STAGE 2 PRESSURE INJURY . -Minimum Data Set, dated [DATE], indicated a BIMS score of 14 (cognitively intact); requires moderate to maximal assistance in toileting and transferring; -Progress Notes, dated October 16, 2025, at 11:47 a.m., indicated, .Skin Check .Coccyx .Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis (the thick, vascular middle layer of skin located directly beneath the epidermis [the thin, outermost layer of your skin that acts as a protective barrier against germs, locks in body moisture, and gives your skin its color] and above the subcutaneous fat layer). Further review of Resident 1's record indicated there was no complete assessment documented on the wound on the coccyx, which includes size of the wound, wound bed description, and drainage. -Progress Notes, dated October 22, 2025, at 8:13 a.m., indicated, .Coccyx .Stage 2 Pressure Injury .Length (cm - centimeters [unit of measurement]) 1.3 Width (cm): 1.1 Depth (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(cm) 0.3 .Granulation (new tissue and tiny blood vessels that grow from the base of a wound during the healing process) 10%. Slough (a layer of soft, moist, dead tissue that forms over a wound). Exudate amount: Light . -Progress Notes, dated October 22, 2025, at 11:31 a.m., indicated, .(name of Wound Physician [WP]) in to assess resident, coccyx injury stage 2 1.3 x (by) 1.1 x 0.3 purulent small drainage, 90 slough, 10 gran. DC (discontinue) current tx and start Silvadene and Hydrogel QD (once a day) . -Physician's order, dated October 22, 2025, indicated, .TX: COCCYX PRESSURE INJURY STG 2: CLEANSE WITH NS (normal saline), PAT DRY APPLY SILVADENE CREAM AND HYDROGEL AND COVER WITH DRY DRESSING QD . -Wound Progress Note, dated October 22, 2025, documented by the WP, indicated, .Coccyx .Stage 2 .Slough (blank) .Granulation tissue: 10% granulation 100% red tissue .Dressing Choice .silvadene, foam QD . On July 13, 2026, at 11:51 a.m., during a concurrent interview and review of Resident 1'sd record was conducted with the WP, the WP stated the following: -He comes to the facility to conduct wound care and management every Wednesday at around 6 a.m.; -The TXN would give him a list of residents to see for wound care and the wound assessment and recommendations were being document on a temporary spreadsheet which includes wound assessment of wound location, size, wound bed description, drainage, and treatment recommendations; -Resident 1's wound on the coccyx was initially assessed by him and the previous TXN on October 22, 2025, and was assessed as Stage 2 with 100% red tissue wound bed. The WP stated the documentation on his wound notes, dated October 22, 2025, indicating 10% granulation tissue was a typographically error. The WP stated the wound on Resident 1's coccyx is stage 2 with treatment recommendation of Silvadene cream and cover with foam dressing . -Stated the physician's order transcribed by the previous TXN of Silvadene with Hydrogel was incorrect. The WP stated the treatment order should have been only Silvadene cream and without Hydrogel; -Stated the previous TXN should have documented complete wound assessments which include the location, size, wound bed description, and drainage, to determine if the wound is improving or worsening. A review of the facility's policy and procedure titled, Skin and Wound Monitoring and Management, revised December 2025, indicated, .A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing .Resident Assessment: The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions .Skin and wound assessment on admission and readmission .A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented on the Initial admission Record .A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not limited to .measuring the skin injury .Staging the skin injury (when the cause is pressure) .Describing the nature of the injury .describing the location of the skin alteration .Describing the characteristics of the skin alteration .Ongoing Skin and Wound Assessments .A licensed nurse will assess/evaluate a resident's skin at least weekly .Areas of breakdown, excoriation, or discoloration, or other unusual findings .must be documented in the nursing notes or on the appropriate weekly assessment form .Treatment per physician order, should be documented in the resident's clinical record at the time they are administered .		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a toileting program was implemented to address bowel and bladder incontinence (involuntary loss of bladder or bowel control), for one of three residents reviewed (Resident 1). In addition, there was no plan of care developed to address Resident 1's bowel and bladder incontinence. This failure had the potential to place Resident 1 at risk for complications such as urinary tract infections, skin breakdown, or kidney damage. Findings: On July 10, 2026, at 11:21 a.m., an unannounced visit to the facility was conducted to investigate quality-of-care issues. On July 10, 2026, Resident 1's record was reviewed. Resident 1's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included left femur (thighbone - running from hip to knee) fracture (break). A review of Resident 1's Bowel and Bladder (B & B) Evaluation, dated October 8, 2025, indicated the resident is a likely candidate for bowel and bladder re-training (behavioral therapies that help regain control over urinary urgency, leakage, and fecal consistency, including scheduled toileting. A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated October 15, 2025, indicated the following: -BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact); -Toilet transfer not attempted due to medical condition; and -Frequently incontinent in bladder (episodes of incontinence with episode of continent voiding). A review of Resident 1's care plans indicated there was no care plan initiated to address Resident 1's B & B incontinence and plan for B & B retraining program as indicated in the B & B evaluation, dated October 8, 2025. Further review of Resident 1's record indicated there was no B & B re-training program implemented to evaluate the resident's potential to regain bowel and bladder continence. On July 13, 2026, at 12:30 p.m., during an interview with the MDS Nurse (MDSN), the MDSN stated B & B evaluation were to be completed on the third (3rd) day of admission. The MDSN stated the MDSN Assistant (MDSNA) was responsible to complete the B & B evaluation and to proceed on implementing a plan of care to address the residents' needs. In a concurrent interview with the MDSNA, she stated the B & B evaluation were to be completed on the 3rd day of admission to evaluate if the resident could benefit on any toileting program to address B & B incontinence. The MDSNA stated the B & B evaluation was done on the day of admission and was not re-evaluated on the 3rd day of admission. The MDSNA stated the B & B evaluation indicated Resident 1 is a likely candidate for B & B re-training, which includes assisting the resident to the bathroom upon waking up, before and after meals, and at bedtime. The MDSNA stated this was not done. the MDSNA stated there was no care plan developed to address Resident 1's B & B incontinence. A review of the facility's policy and procedure titled, Bowel and Bladder Assessment, revised April 2026, indicated, .The purpose of the bowel and bladder assessment is to offer a structured, goal-oriented approach with the intent that the resident attains the highest level of independence in bowel and/or bladder continence. This program will also focus on the residents' ability to improve continence independently .Complete a bowel and bladder evaluation within seventy-two (72H) of admission .The facility shall initiate a bowel and bladder re-training program, once the resident is determined to have a potential for re-training .Resident's care plan will be updated accordingly.		