

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East Bastanchury Fullerton, CA 92835	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40617 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to protect the resident's rights from the verbal and physical abuses by another resident for two of six sampled residents (Residents 2 and 3). * Resident 1 was being assisted by two nursing aide students when Resident 1 angrily yelled and demanded Resident 2 to leave Room A. Resident 1 hit Resident 2's right foot as witnessed by the two nursing aide students on 11/16/24. Resident 2 was assessed with no physical injuries, monitored for emotional distress, and transferred to Room B. * CNA 3 witnessed Resident 1 yelling and cursing at Resident 3 on 12/13/24. Resident 3 stated Resident 1 also raised his walker as if going to hit him. Resident 3 stated he felt scared to go back to Room A. Resident 3 was then transferred to Room C. These failures had the potential to cause further serious injuries and/or psychosocial harm to Residents 2 and 3, and risk to other residents. Findings: Review of the facility's P&P titled Preventing Abuse revised 12/2023 showed the facility does not condone any form of resident abuse, and the facility's goal was to achieve and maintain an abuse-free environment. The P&P showed the facility's abuse prevention/intervention program included assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect. Review of the facility document titled #171 Physical Aggression Initiated dated 11/16/24, showed a statement by RN 3. RN 3's statement showed they received a report from a CNA who stated two nursing aide students had witnessed Resident 1 pulled Resident 2's privacy curtain, yelled angrily at Resident 2 and demanded Resident 2 to leave the room. The statement further showed the two nurse aide students hadwitnessed Resident 1 hitting Resident 2 on the right foot. Review of the facility document titled Staff Statement dated 11/16/24, showed the statements by the two nurse aide students. The statements included the following: (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 2 was watching TV when Resident 1 aggressively opened his curtain, yelled at him, and then hit him on the right foot. - The two nurse aide students were assisting Resident 2 to the bathroom when Resident 1 pulled open Resident 2's curtain and angrily demanded for him to leave, and that was when Resident 1 intentionally hit him and Resident 2 flinched and screamed Oh. a. Medical record review for Resident 1 was initiated on 12/3/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severe cognitive impairment, with no impairment to upper and lower extremities, and required supervision/ touching assistance with bed mobility. Review of Resident 1's H&P evaluation dated 11/8/24, showed Resident 1 was originally admitted to the SNF for aggressive behavior and increasing confusion. Review of Resident 1's SBAR Communication Form and Progress Note - V4 dated 11/16/24, showed on 11/16/24 at 1150 hours, physical aggression was initiated manifested by hitting his roommate on the right foot with his hand. Review of Resident 1's Progress Notes, under Incident Note dated 11/16/24 at 1420 hours, showed at around 1200 hours, RN 3 informed LVN 2 that two CNA students reported Resident 1 hit Resident 2's right foot with fist. b. Medical record review for Resident 2 was initiated on 12/3/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident 2 had hearing and speech impairment but was cognitively intact and required substantial/maximal assistance with self-care and mobility. Review of Resident 2's SBAR Communication Form and Progress Note - V4 dated 11/16/24, showed on 11/16/24 at 1150 hours, Resident 2 was the subject of physical aggression, was hit on the right foot by roommate without provocation. On 12/18/24 at 1041 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 2 was deaf and mute, but could communicate with a board, or with hand gestures. CNA 1 stated Resident 1 could not speak in English and could only speak and understand a foreign language. CNA 1 stated Resident 1 could walk using a walker by himself. CNA 1 stated Resident 1 had a history of being verbally aggressive. CNA 1 stated she heard Resident 1 saying, Who is he? What is he doing here? in an angry voice, cursing, and referring to Resident 2. CNA 1 stated she did not remember the exact date, but it happened two to three times, and she had always reported each time to RN 3. CNA 1 stated the licensed nurses asked her to calm Resident 1 down. On 12/18/24 at 1149 hours, a concurrent interview and medical record review for Residents 1 and 2 was conducted with RN 1. RN 1 stated Resident 2 had history of being verbally and physical aggressive to the staff, but not to the resident. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 1348 hours, a telephone interview was conducted with RN 3. RN 3 stated on 11/16/24, she was approached by the two nurse aide students and CNA 4. RN 3 stated the two nurse aide students reported to her that they had witnessed Resident 1 pulled Resident 2's privacy curtain open and Resident 1 hit Resident 2's right foot. Cross references to F609 and F610. 2. Review of the facility's SOC 341 dated 12/18/24, identified the facility had reported an allegation of resident-to-resident verbal abuse on 12/13/24. Resident 1 allegedly yelled and used profanity in a foreign language directed at Resident 3. Resident 3 stated Resident 1 attempted to lift his walk like he was going to throw it at him. Review of the facility's document titled Staff Interview with CNA 3 dated 12/18/24, showed CNA 3 was trying to help Resident 3 get into the bed when Resident 1 started yelling. Resident 1 was holding his walker and tried to suddenly lift it up, but he did not throw it at him. a. Review of Resident 1's Progress Notes dated 12/13/24, showed at approximately 1835 hours, Resident 3 approached RN 2 and stated Resident 1 had been yelling and used profanity against him. Resident 1 stated Resident 3 told him that he owned the facility and for Resident 3 to leave the room. The note further showed per Resident 3, he was afraid Resident 1 will do something to him while he was asleep and was starting to get emotionally affected by his verbal abuse. RN 2 went to talk to Resident 1 and explained to him about his new roommate, but Resident 1 yelled and used profanity. Resident 1 insisted he did not want a roommate in his room. Resident 3 was then transferred to another room. b. Medical record review for Resident 3 was initiated on 12/3/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS dated [DATE], showed Resident 3 was cognitively intact, with impairment to one side of lower extremities, and required supervision/touching assistance with bed mobility. On 12/18/24 at 1428 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated Resident 3 was transferred to Room A, with Resident 1 as his roommate. RN 2 stated Resident 3 informed her that Resident 1 yelled at him and told him to get out. RN 2 stated when she spoke with Resident 1, he used profanity in a foreign language. RN 2 stated Resident 3 was transferred to another room. RN 2 stated she reported this incident to the DON. RN 2 stated she documented the incident in Resident 1's progress notes but did not complete it and the documentation remained as a draft. RN 2 verified there was no documentation Residents 1 and 3 were monitored by the facility staff after the incident. The SSD did not monitor Residents 1 and 3. On 12/18/24 at 1454 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with the SSD. When asked about an incident between Residents 1 and 3, the SSD stated she was informed by Resident 3 about Resident 1 yelling at him. The SSD stated Resident 3 just wanted to change his room. The SSD stated she documented the incident in Resident 1's progress notes but did not complete it and the documentation remained as a draft. The SSD was not able to show documentation. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1523 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with the DSD. The DSD stated she was responsible for providing in-services to the staff including abuse training. The DSD stated there should be a willful intention to harm to be considered an abuse. The DSD stated the person who was the alleged abuser had to have an intention, and the alleged victim must feel threatened or harm. When asked about the incident between Residents 1 and 3, the DSD stated she was not aware of the incident, but did not consider this as a verbal abuse, because it has not happened yet. When asked to elaborate, the DSD stated Resident 3 reported Resident 1 yelled at him and was scared to go back to the room because Resident 1 might do something to him, but nothing happened yet. On 12/18/24 at 1547 hours, an interview was conducted with Resident 3. Resident 3 stated he was transferred to Room A on 12/13/24, after lunchtime. Resident 3 stated he had a few hours in the room when he tried to speak with Resident 1. Resident 3 stated, the first word that came out of his mouth was profanity, and Resident 1 yelled at him in an angry tone. Resident 3 stated Resident 1 saw another side of him, and he was violent. He raised his walker as if he is going to hit me with the walker. Resident 3 stated he did not trust Resident 1, and felt that Resident 1 was going to hurt him. Resident 3 stated, I will not let him treat me like a pet or a dog. Resident 3 stated Resident 1 could walk and could attack anybody at any moment. Resident 3 stated, Overall, I feel safe. I just have to know where to go and who not to speak to. Resident 3 stated he reported this to RN 2, CNA 3, and the SSD. On 12/18/24 at 1624 hours, a concurrent interview, medical record review, and facility document review for Residents 1, 2, and 3, was conducted with the DON. The DON verified the above findings. The DON stated RN 2 informed her about the incident between Residents 1 and 3, but she was told that Resident 1 was yelling and using in profanity not directed against Resident 3, and it was more of incompatibility, meaning they were not compatible as roommates. On 12/19/24 at 1551 hours, a concurrent interview, medical record review, and facility document review for Residents 1 and 3 was conducted with the DON, with the SSD present. The DON stated she spoke to CNA 3 on 12/18/24, and CNA 3 informed her that she was in Room A when she heard Resident 1 yelling at Resident 3, and Resident 3 even tried to calm Resident 1 down, and CNA 3 stated Resident 1 slightly lift his walker but did not throw it at Resident 3. Cross references to F609 and F610.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40617 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility did not report the allegation of abuse timely as per the facility's P&P for two of six sampled residents (Resident 2 and 3) * Resident 1 was being assisted by two nurse aide students when Resident 1 angrily yelled and demanded Resident 2 to leave Room A. Resident 1 hit Resident 2's right foot as witnessed by the two nurse aide students, on 11/16/24. Resident 2 was assessed with no physical injuries, monitored for emotional distress, and was then transferred to Room B. The initial SOC-341 filed to CDPH on 11/16/24, was incomplete and did not show the description of the incident. Additional information to show the description of the incident was filed on 11/18/24, which was 48 hours after the incident. * CNA 3 witnessed Resident 1 yell and curse at Resident 3 on 12/13/24. Resident 3 stated Resident 1 also raised his walker as if to hit him. Resident 3 stated he felt scared to go back to Room A. Resident 3 was then transferred to Room C. This incident was reported to RN 2 by Resident 3 on 12/13/24. However, this was not reported to the CDPH, L&C Program, ombudsman office, and law enforcement agency. The SOC 341 was filed on 12/18/24, which was five days after the incident. This failure posed the risk for resident abuse not being identified and reported at a facility with a highly vulnerable resident population and posed the risk of continued abuse of the residents. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 1/2023 showed the following: - All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies as required by current regulations, and thoroughly investigated by facility management. - If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law; - The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: (a) the state licensing/certification agency responsible for surveying/licensing the facility; (b) the local/state ombudsman; (c) the resident's representative; (d) the law enforcement officials; (e) the resident's attending physician; and (f) the facility medical director; (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Immediately is defined as (a) within two hours of an allegation involving abuse or result in serious bodily injury; or (b) within 24 hours of an allegation that does not involve abuse or result in serious bodily injury; and - Notices include, as appropriate: (a) the resident's name; (b) the resident's room number; (c) the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); (d) the date and time the alleged incident occurred; (e) the name(s) of all persons involved in the alleged incident; and (f) what immediate action was taken by the facility. 1. Review of the facility's SOC 341 dated 11/16/24, showed the facility had reported an allegation of physical abuse on 11/13/24, which identified Resident 2 as the alleged victim, and Resident 1 as the alleged suspected abuser. Further review of the SOC 341 form showed Section C, (Reporter's observations, beliefs, and statements by victim if available) was not completed. The SOC 341 further failed to show a description of the incident, and the immediate actions taken by the facility. This was faxed to CDPH, L&C Program on 11/16/24. Review of the facility document titled #171 Physical Aggression Initiated dated 11/16/24, showed a statement by RN 3. RN 3's statement showed they received report from a CNA who stated two nurse aide students had witnessed Resident 1 pulled Resident 2's privacy curtain, yelled angrily at Resident 2, and demanded Resident 2 leave the room. The statement further showed the two nurse aide students witnessed Resident 1 hitting Resident 2 on the right foot. This was sent electronically to CDPH, L&C Program on 11/18/24, which was 48 hours after the incident. On 12/18/24 at 1624 hours, a concurrent interview, medical record review, and facility document review for Residents 1 and 2 was conducted with the DON. The DON verified the above findings. The DON verified the SOC 341 was initially filed on 11/16/24, and the DON verified the SOC 341 form was incomplete as RN 3 did not provide the description of the incident. The DON stated she emailed the additional information on 11/18/24. 2. Review of the facility's SOC 341 dated 12/18/24, identified the facility had reported an allegation of resident-to-resident verbal abuse on 12/13/24. Resident 1 allegedly yelled and used profanity in a foreign language directed at Resident 3. Resident 3 stated Resident 1 attempted to lift his walk like he was going to throw it at him. a. Review of Resident 1's Progress Notes dated 12/13/24, showed at approximately 1835 hours, Resident 3 approached RN 2 and stated Resident 1 had been yelling and used profanity against him. Resident 1 stated Resident 3 told him that he owned the facility and for Resident 3 to leave the room. The note further showed per Resident 3, he was afraid that Resident 1 will do something to him while he was asleep, and that he was starting to get emotionally affected by his verbal abuse. RN 2 went to talk to Resident 1 and explained to him about his new roommate, but Resident 1 yelled and used profanity. Resident 1 insisted he did not want a roommate in his room. Resident 3 was then transferred to another room. Further review of Resident 1's medical record did not show this incident was reported to any appropriate agencies. b. Medical record review for Resident 3 was initiated on 12/3/24. Resident 3 was admitted to the facility on [DATE]. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's MDS dated [DATE], showed Resident 3 was cognitively intact, with impairment to one side of lower extremities, and required supervision/touching assistance with bed mobility. Further review of Resident 3's medical record did not show this incident was reported to any appropriate agencies. On 12/18/24 at 1428 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated Resident 3 was transferred to Room A, with Resident 1 as his roommate. RN 2 stated Resident 3 informed her that Resident 1 yelled at him and told him to get out. RN 2 stated when she spoke with Resident 1, he used profanity in a foreign language. RN 2 stated she did not think it was a verbal abuse because Resident 1 had been using profanity directed at everyone. RN 2 stated Resident 3 was transferred to another room. RN 2 stated she reported this incident to the DON. On 12/18/24 at 1454 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with the SSD. When asked about an incident between Residents 1 and 3, the SSD stated she was informed by Resident 3 about Resident 1 yelling at him. The SSD stated Resident 3 just wanted to change the room. The SSD acknowledged she did not report this incident to the appropriate agencies. On 12/18/24 at 1547 hours, an interview was conducted with Resident 3. Resident 3 stated he was transferred to Room A on 12/13/24. Resident 3 stated he tried to speak to Resident 1, but Resident 1 yelled at him in an angry tone. Resident 3 stated Resident 1 raised his walker as if he is going to hit me with the walker. Resident 3 stated he reported this to RN 2, CNA 3, and the SSD. On 12/18/24 at 1624 hours, a concurrent interview, medical record review, and facility document review for Residents 1, and 3, was conducted with the DON. The DON verified the above findings. The DON stated RN 2 informed her about the incident between Residents 1 and 3 on 12/13/24, but she was told Resident 1 was yelling and using in profanity not directed against Resident 3, and it was more of incompatibility, meaning they were not compatible as roommates. The DON stated she did not report this incident to the appropriate agencies.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40617 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to investigate an allegation of abuse as per the facility's P&P and monitor the residents after the alleged abuse for three of three sampled residents (Residents 1, 2, and 3). * Resident 1 was being assisted by two nurse aide students, when Resident 1 angrily yelled and demanded Resident 2 to leave Room A. Resident 1 hit Resident 2's right foot, as witnessed by the two nurse aide students, on 11/16/24. Resident 2 was assessed with no physical injuries, monitored for emotional distress, and was then transferred to Room B. The facility failed to interview staff members on all shifts who had a contact with the resident during the period of the alleged incident as per the facility's P&P. Furthermore, the facility failed to ensure the SSD visited Residents 1 and 2 daily for 72 hours, as per the facility's investigation report. * CNA 3 witnessed Resident 1 yell and curse at Resident 3 on 12/13/24. Resident 3 stated Resident 1 also raised his walker as if to hit him. Resident 3 stated he felt scared to go back to Room A. Resident 3 was then transferred to Room C. This incident was reported to RN 2 by Resident 3 on 12/13/24. The facility failed to ensure this incident was further investigated. These failures posed the risk for resident abuse not being identified and investigated, at a facility with a highly vulnerable resident population. Failure to conduct an abuse investigation posed the risk for continued abuse of the residents. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 1/2023 showed the individual conducting the investigation as a minimum, interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 1. Review of the facility document titled #171 Physical Aggression Initiated dated 11/16/24, showed a statement by RN 3. RN 3's statement showed they received report from a CNA who stated two nurse aide students had witnessed Resident 1 pulled Resident 2's privacy curtain, yelled angrily at Resident 2, and demanded Resident 2 to leave the room. The statement further showed the two nurse aide students witnessed Resident 1 hitting Resident 2 on the right foot. This was sent electronically to CDPH, L&C Program on 11/18/24, which was 48 hours after the incident. a. Review of the facility's investigation report showed interview statements from the two nursing aide students, LVN 2, and RN 3. Further review of the investigation report did not show interviews with the staff members (on all shifts) who had a contact with the resident during the period of the alleged incident were conducted. b. Further review of the facility's document titled Investigation Report Statement dated 11/20/24, regarding the incident between Residents 1 and 2 showed the actions taken by the facility included daily visits to Residents 1 and 2 by the SSD for 72 hours. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Medical record review for Resident 1 was initiated on 12/3/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE] showed Resident 1 had severe cognitive impairment, with no impairment to upper and lower extremities, and required supervision/ touching assistance with bed mobility. Review of Resident 1's Progress Notes, under Social Service Note, showed the following: - On 11/18/24 at 1039 hours, showed a late entry documentation entry by the SSD, showing the SSD visited Resident 1; and - On 11/20/24 at 1406 hours, showed a late entry documentation entry by the SSD, showing the SSD visited Resident 1. Further review of Resident 1's medical record review did not show Resident 1 was visited daily by the SSD for 72 hours. d. Medical record review for Resident 2 was initiated on 12/3/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE] showed Resident 2 had hearing and speech impairment but was cognitively intact and required substantial/maximal assistance with self-care and mobility. Review of Resident 2's Progress Notes, under the Social Service Note, showed the following: - On 11/18/24 at 1108 hours, showed a late entry documentation entry by the SSD, showing the SSD visited Resident 2; and - On 11/20/24 at 1030 hours, showed a late entry documentation entry by the SSD, showing the SSD visited Resident 2. Further review of Resident 1's medical record review did not show Resident 1 was visited daily by the SSD for 72 hours. On 12/18/24 at 1454 hours, a concurrent interview and medical record review for Residents 1 and 2 was conducted with the SSD. When asked about the SSD daily visits for 72 hours, the SSD stated she was supposed to check on the residents and monitor how they were after the incident, daily for three to four days. The SSD stated the incident between Residents 1 and 2 happened on 11/16/24, which was a weekend, so she initiated her visit on 11/18/24. Review of Residents 1 and 2's medical records showed the SSD visited them on 11/18 and 11/20/24. The SSD verified she missed one visit for each resident. On 12/18/24 at 1624 hours, a concurrent interview, medical record review, and facility document review for Residents 1 and 2 was conducted with the DON. The DON verified the above findings. When asked about the interviews conducted regarding the incident between Residents 1 and 3, the DON verified the report only included the interview statements from the two nurse aide students, LVN 2, and RN 3. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's SOC 341 dated 12/18/24, identified the facility had reported an allegation of resident-to-resident verbal abuse on 12/13/24. Resident 1 allegedly yelled and used profanity in a foreign language directed at Resident 3. Resident 3 stated Resident 1 attempted to lift his walk like he was going to throw it at him. a. Review of Resident 1's Progress Notes dated 12/13/24, showed at approximately 1835 hours, Resident 3 approached RN 2 and stated Resident 1 had been yelling and used profanity against him. Resident 1 stated Resident 3 told him that he owned the facility and for Resident 3 to leave the room. The note further showed per Resident 3, he was afraid that Resident 1 will do something to him while he was asleep and was starting to get emotionally affected by his verbal abuse. RN 2 went to talk to Resident 1 and explained to him about his new roommate, but Resident 1 yelled and used profanity. Resident 1 insisted he did not want a roommate in his room. Resident 3 was then transferred to another room. Further review of Resident 1's medical record did not show any monitoring or investigation of the alleged verbal abuse between Residents 1 and 3. b. Medical record review for Resident 3 was initiated on 12/3/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS dated [DATE], showed Resident 3 was cognitively intact, with impairment to one side of lower extremities, and required supervision/touching assistance with bed mobility. Further review of Resident 3's medical record did not show any monitoring, reporting, or investigation of the alleged verbal abuse between Residents 1 and 3. On 12/18/24 at 1428 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated Resident 3 was transferred to Room A, with Resident 1 as his roommate. RN 2 stated Resident 3 informed her that Resident 1 yelled at him and told him to get out. RN 2 stated when she spoke with Resident 1, he used profanity in a foreign language. RN 2 stated she did not think it was a verbal abuse because Resident 1 had been using profanity directed at everyone. RN 2 stated Resident 3 was transferred to another room. RN 2 stated she reported this incident to the DON. RN 2 acknowledged she did not investigate the incident between Residents 1 and 3. On 12/18/24 at 1454 hours, a concurrent interview and medical record review for Residents 1 and 3 was conducted with the SSD. When asked about an incident between Residents 1 and 3, the SSD stated she was informed by Resident 3 about Resident 1 yelling at him. The SSD acknowledged she did not investigate the incident between Residents 1 and 3. On 12/18/24 at 1547 hours, an interview was conducted with Resident 3. Resident 3 stated he was transferred to Room A on 12/13/24. Resident 3 stated he tried to speak to Resident 1, but Resident 1 yelled at him in an angry tone. Resident 3 stated Resident 1 raised his walker as if he is going to hit me with the walker. Resident 3 stated he reported this to RN 2, CNA 3, and the SSD. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East Bastanchury Fullerton, CA 92835	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1624 hours, a concurrent interview, medical record review, and facility document review for Residents 1, and 3, was conducted with the DON. The DON verified the above findings. The DON stated RN 2 informed her about the incident between Residents 1 and 3 on 12/13/24, but she was told Resident 1 was yelling and using profanity not directed against Resident 3, and it was more of incompatibility, meaning they were not compatible as roommates. The DON stated she did not investigate the incident between Residents 1 and 3.		