STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555671	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace View Care Center	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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 four sampled residents (Resident 1) was free from the physical restraints. * CNA 1 wrapped a bed sheet around Resident 1's waist and tied it behind the resident's wheelchair, preventing Resident 1 from easily removing the material. This failure posed the risk of restricting the resident's freedom of movement and further compromising the resident's independence and psychosocial well-being. Findings: Review of the facility's P&P titled Use of Restraint dated 2024 showed the restraints shall only be used for the safety and well-being of the resident (s) and only after other alternatives have been tried unsuccessfully. Restraint shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. The P&P showed practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including:- tucking sheet so tightly that a bed-bound resident cannot move; and,- placing the resident in a chair that prevents resident from rising. Further review of the P&P showed the restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. On 9/28/25, the CDPH, L&C Program received a report from the facility. The report showed Resident Representative 1 found Resident 1 with a sheet of linen wrapped around him and tied at the back of the wheelchair. Medical record review for Resident 1 was initiated on 10/8/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/19/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderate cognitive impairment. Review of Resident 1's SBAR dated 9/28/25, showed at 0700 hours, Resident Representative 1 found Resident 1 with a bedsheet around his waist tied at the back of the wheelchair. Resident 1 was in the dining room with CNA 1 beside him charting. The SBAR further showed Resident 1 was assessed with no visible injury at the time; however, a full skin assessment on 9/28/25 at 1000 hours, showed discoloration was observed on Resident 1's bilateral legs and arms. Further review of the SBAR showed the alleged staff was suspended while pending further investigation. Review of Resident 1's medical record failed to documented evidence of a physician's order or any documentation of a medical necessity for the use physical restraints. On 10/8/25 at 1231 hours, an interview was conducted with Resident 1 in his room with translation from Resident Representative 2 at the bedside. Resident 1 stated the staff in the facility tied him in the wheelchair and he could not move freely. Resident 1 stated he did not remember the date and time or how long he was tied by the bed sheet in the wheelchair. Resident 1 stated he was scared and called his son. On 10/8/25 at 1328 hours, a telephone interview was conducted with Resident Representative 1. Resident Representative 1 stated on 9/28/25 at around 0600 hours, he received a call from Resident 1 stating he would call police. Resident Representative 1 stated he asked the resident why he wanted to call police. Resident 1 told Resident Representative 1 he was tied to the wheelchair. Resident Representative 1 stated he lived close to the facility, so he drove to the facility. Resident Representative 1 stated he saw Resident 1 in the dining room sitting in the wheelchair which was wrapped with the bed sheet and tied at the back of the wheelchair. Resident Representative 1 stated Resident 1 was restricted from freely moving, and CNA 1 was next to the resident working on the computer. Resident Representative 1 stated he asked CNA 1 to untie Resident 1 and reported the incident to a charge nurse. On 10/9/25 at 1001 hours, a telephone interview was conducted with CNA 1. CNA 1 stated on around 9/28/25, during the night shift, Resident 1 frequently got out of his bed without asking for staff assistance. CNA 1 stated Resident 1 had risk of falling and the CNA also had to take care of other residents. CNA 1 stated he decided to put Resident 1 on the wheelchair on 9/28/25, at around 0500 hours. CNA 1 further stated for Resident 1's safety, he put the bed sheet around Resident 1's waist and loosely tied it to the wheelchair so he could not stand on his own. CNA 1 further stated he should not have tied Resident 1 to the wheelchair, and he should have reported the resident's condition of getting out of bed to the charge nurse assigned to the resident. On 10/9/25 at 1202 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on around 9/28/25 at 0630 hours, she was looking for CNA 1 and saw them in the dining room documenting on the computer with Resident 1. LVN 1 stated she saw the resident

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(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	Respond appropriately to all alleged violations. (continued on next page)

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(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	**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 thoroughly investigate an allegation of abuse for one of four sampled residents (Resident 1). * The facility failed to interview Resident 1 (alleged victim) and CNA 1 (alleged perpetrator) when Resident Representative 1 reported Resident 1 was tied to his wheelchair with a bedsheet, and when Resident 1 alleged CNA 1 hit him in the face and kicked him in the stomach. This failure had the potential to put the resident at risk for further abuse.Findings: Review of the facility's P&P titled Elder/Dependent Adult Abuse dated 2/2023 showed under the section Investigation/Action, the facility will:- identify and interview all persons involved including alleged victim, perpetrator, witness, others who may have knowledge of alleged violation;- focus on determining if abuse, neglect, exploitation or mistreatment has occurred and the extent/cause;- document evidence that all alleged abuse violations are thoroughly investigated; and,- take all necessary action as a result of the investigation. On 9/28/25, the CDPH, L&C Program received a report from the facility. The report showed Resident Representative 1 found Resident 1 with a sheet of linen wrapped around him and tied at the back of the wheelchair. Resident Representative 1 also reported Resident 1 alleged he was hit, slapped on the head and kicked on the stomach. On 10/8/25 at 1231 hours, an interview was conducted with Resident 1 in his room with translation from Resident Representative 2 at the bedside. Resident 1 stated the staff in the facility tied him in the wheelchair and he could not move freely. Resident 1 stated he did not remember the date and time or how long he was tied by the bed sheet in the wheelchair. Resident 1 stated he was scared and called his son. On 10/8/25 at 1328 hours, a telephone interview was conducted with Resident Representative 1. Resident Representative 1 stated on 9/28/25 at around 0600 hours, he received a call from Resident 1 stating he would call police. Resident Representative 1 stated he asked the resident why he wanted to call police. Resident 1 told Resident Representative 1 he was tied to the wheelchair. Resident Representative 1 stated he lived close to the facility, so he drove to the facility. Resident Representative 1 stated he saw Resident 1 in the dining room sitting in the wheelchair which was wrapped with the bed sheet and tied at the back of the wheelchair. Resident Representative 1 stated Resident 1 was restricted from freely moving, and CNA 1 was next to the resident working on the computer. Resident Representative 1 stated he asked CNA 1 to untie Resident 1 and reported the incident to a charge nurse. Resident Representative 1 further stated Resident 1 also claimed a facility staff hit, slapped his head and kicked his abdomen. On 10/8/25 at 1338 hours, an interview was conducted with Resident 1 with translation from the OT . Resident 1 stated the facility staff had hit, slapped his head and kicked his stomach. Resident 1 stated he had not seen the staff after the incident, but was scared that the staff would come back. Medical record review for Resident 1 was initiated on 10/8/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/19/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderate cognitive impairment and required maximum staff assistance for his activities of daily living. Review of the facility's investigation and interviews conducted from 9/28/25 to 9/29/25, did not show Resident 1 (alleged victim) was interviewed. Additionally, there was no documented evidence CNA 1 (alleged perpetrator) was interviewed regarding the incident. Review of the facility's document titled Investigation Report Statement dated 10/2/25, showed on 9/28/25, Resident Representative 1 reported observing Resident 1 in the wheelchair with a bedsheet wrapped around him in the dining room beside a CNA who was charting. Resident 1 called Resident Representative 1 via phone and said he was hit, slapped on his head and kicked on the stomach. The document further showed based on clinical record review, interview and thorough assessment, there were no witnesses who were able to validate the allegation. Further review of the report showed the facility took the following steps to investigate the incident:- interviewed resident's family member- interviewed resident through family member's assistance- thoroughly assessed resident for injury, skin discoloration or other skin issue and daily body check was done for five days- interviewed all the staff of the shift when incident was reported and all the staff who had direct care to the resident for the past 72 hours prior to the incident- interviewed appropriate staff or individuals that may or may not directly involvement or knowledge of the incident On 10/9/25 at 1115 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated she investigated the allegation reported by Resident Representative 1 involving Resident 1 and CNA 1. The DON

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 provide the treatment and care in accordance with the professional standards of practice for one of four sampled residents (Resident 1). * The facility failed to ensure the physician was notified in a timely manner when Resident Representative 1 reported Resident 1 was tied to his wheelchair with a bedsheet, and when Resident 1 alleged CNA 1 hit him in the face and kicked him in the stomach * The facility failed to ensure the physician and resident representative were notified when Resident 1 was found on the floor and was observed with purplish discoloration on his left thigh. In addition, the facility failed to ensure monitoring of the neurological status was conducted when the resident had unwitnessed fall. These failures had the potential for Resident 1 not to receive appropriate care and treatment.Findings: Review of the facility's P&P titled Acute Condition Changes- Clinical Protocol dated 12/2024 showed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. The nursing staff will contact the physician based on the urgency of the situation. For emergencies they will call or page the physician and request prompt response (within approximately one-half hour or less). The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition or status. The staff will notify the Medical Director for additional guidance and consultation if they do not receive a timely or appropriate response. 1. On 10/8/25 at 1328 hours, a telephone interview was conducted with Resident Representative 1. Resident Representative 1 stated on 9/28/25 at around 0600 hours, he received a call from Resident 1 stating he would call police. Resident Representative 1 stated he asked the resident why he wanted to call police. Resident 1 told Resident Representative 1 he was tied to the wheelchair. Resident Representative 1 stated he lived close to the facility, so he drove to the facility. Resident Representative 1 stated he saw Resident 1 in the dining room sitting in the wheelchair which was wrapped with the bed sheet and tied at the back of the wheelchair. Resident Representative 1 stated Resident 1 was restricted from freely moving, and CNA 1 was next to the resident working on the computer. Resident Representative 1 stated he asked CNA 1 to untie Resident 1 and reported the incident to a charge nurse. Resident Representative 1 further stated Resident 1 also claimed a facility staff hit, slapped his head and kicked his abdomen. Medical record review for Resident 1 was initiated on 10/8/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/19/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderate cognitive impairment and required maximum staff assistance for his activities of daily living. Review of Resident 1's SBAR dated 9/28/25, showed at 0700 hours, Resident Representative 1 found Resident 1 with bedsheet around his waist tied at the back of the wheelchair. Resident 1 was in the dining room with CNA 1 beside him charting. The SBAR further showed Resident Representative 1 reported Resident 1 claimed he was hit, slapped on the head and kicked on the stomach. The SBAR further showed Resident 1 was assessed with no visible injury at the time; however, a full skin assessment on 9/28/25 at 1000 hours, showed discoloration was observed on Resident 1's bilateral legs and arms. Further review of the SBAR showed the incident was reported to the Primary Care Clinician on 9/28/25 at 1400 hours (approximately seven hours after the incident and the allegation was reported to the facility staff). On 10/9/25 at 1414 hours, an interview and medical record review for Resident 1 was conducted with the DON. The DON verified the physician was not notified timely when Resident Representative 1 reported that he observed Resident 1 being tied to the wheelchair by bedsheet and an allegation made by Resident 1 that CNA 1 hit, slapped him in his head, and kicked him in the stomach. The DON verified the above incident was notified to the physician approximately seven hours after the incident and should have been notified timely. 2. Review of the facility P&P titled Falls- Clinical Protocol dated 9/2024 showed under the section monitoring and follow up, the staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complication such as late fracture or subdural hematoma (a collection of blood that accumulates between the brain and the inner layer of the skull) have been ruled out or resolved. Review of the facility's P&P titled Neurological assessment dated 10/2024 showed under the section general guidelines neurological assessment are indicated:- upon physician order;- following an unwitnessed fall;- following a fall or other accident/injury involving head trauma; or- when indicated by resident's condition. Review of Resident 1's Progress Notes dated 9/28/25 at 0031 hours, showed Resident