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	02/23/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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 the personal property was protected from loss or theft for one of three final sampled residents (Resident 14) reviewed for personal property. * The facility failed to ensure Resident 14's CPAP machine was listed in the resident's inventory list. This failure had the potential for the resident's property to get lost or stolen.Findings: Review of the facility's P&P titled Personal Property revised 3/2025 showed the resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. On 2/11/26, Resident 14's Responsible Party filed a complaint with the CDPH office alleging when Resident 14 was transported to their house, the resident received a different CPAP machine than what she provided with the facility. Closed medical record review for Resident 14 was initiated on 2/18/26. Resident 14 was admitted to the facility on [DATE] and discharged on 2/10/26. Review of Resident 14's H&P examination dated 12/19/25, showed Resident 14 did not have the capacity to understand and make decisions. Review of Resident 14's Resident's Clothing and Possessions dated 12/29/25, showed under the admission section, the listed belongings were jackets and shoes. The Discharge section (undated) showed complete personal belonging. Review of Resident 14's Order Summary Report showed a physician's order dated 2/6/26, for the use of CPAP device with pressure setting of 4 cm H2O to 20 cm H2O humidification, via full mask, on at evening shift and off at morning shift for obstructive sleep apnea (sleep disorder where breathing repeatedly stops and starts during sleep reducing the oxygen). Further review of Resident 14's medical record did not show documented evidence the CPAP machine was listed or recorded. On 2/23/26 at 1356 hours, an interview and concurrent medical record review for Resident 14 was conducted with LVN 1. LVN 1 verified she took care of Resident 14 when the resident was admitted in the facility, and she was the one who processed the discharge of the Resident on 2/10/26. LVN 1 verified Resident 14 was using his own CPAP machine in the facility. LVN 1 stated upon resident's admission, the licensed nurses or CNAs would check the resident's belongings, and it would be recorded in the Resident's Clothing and Possessions form they used. LVN 1 stated if new personal items or medical equipment were brought anytime during the stay of the resident in the facility or if the resident's personal item would be taken away by the family member, it would be recorded in the Personal Inventory Update form. Review of the Personal Inventory Update form showed a column for add/delete, description, serial number, and quantity. LVN 1 stated the Personal Inventory Update form should be dated and signed by the resident or family representative. LVN 1 stated when a resident was being discharged from the facility, the licensed nurse would do the inventory list and record what items were being given back to the resident. LVN 1 verified Resident 14's CPAP machine was not listed or recorded in Resident's Clothing and Possessions, and no Personal Inventory Update was completed. LVN 1 verified she was the one who filled up Resident 14's Resident Clothing and Possessions form when the resident (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was discharged on 2/10/26. LVN 1 stated Resident 14's CPAP machine was sent with the resident when he was discharged on 2/10/26. LVN 1 was unable to recall what type of CPAP machine Resident 14 had and what were the other belongings were sent to the resident when she discharged the resident on 2/10/26. LVN 1 further stated she should have recorded each personal item or belonging sent with Resident 14 when the resident was discharged on 2/10/26. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON stated the expectation for the staff was to record or itemize each personal belonging the resident had during admission and update the record if the family member brought a new item or took out an item for the resident. The DON further stated the staff should record each resident's personal item being returned or sent with the resident during discharge. The DON was informed and acknowledged the findings for Resident 14.