

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

Printed: 05/28/2025
Form Approved OMB
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 02/27/2025
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for one of 14 final sampled residents (Resident 33). This failure had the potential for the resident to not receive individualized plans of care to address the resident's individual care needs. Findings: Medical record review for Resident 33 was initiated on 2/24/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Order Summary Report dated 2/25/25, showed a physician's order dated 1/25/25, to administer heparin (anticoagulant medication) 5000 units subcutaneously every 12 hours for DVT prophylaxis. Review of Resident 33's Admission MDS dated [DATE], showed Resident 33 was not coded for the use of an anticoagulant medication. On 2/26/25 at 1511 hours, an interview and concurrent medical record review for Resident 33 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated she coded the MDS assessment incorrectly. On 2/27/25 at 1040 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 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** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for one of 14 final sampled residents (Resident 8) and two nonsampled residents (Residents 26 and 293). * The facility failed to ensure the physician's order was obtained, the assessment was completed, and the appropriate instructions were obtained to maintain the appropriate care of the resident's blood glucose monitoring device for Resident 26. * The facility failed to ensure the transfer orders and instructions from the acute care hospital were followed through and communicated to the resident's attending physician for Resident 293. * The facility failed to assess Resident 8 and notify the physician timely when Resident 8's oxygen saturation levels were 91 to 92% as per the physician's order to keep the oxygen saturation above 92%. These failures had the potential for the residents to not receive the necessary care and services to maintain their highest physical well-being. Findings: 1. Review of the facility's P&P titled Obtaining a Fingerstick Glucose Level dated 3/2024 showed the facility would ensure the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer. On 2/24/24 at 0937 hours, an observation and concurrent interview was conducted with Resident 26. Resident 26 was awake and observed in the bathroom. Resident 26 stated he had diabetes and the facility staff were monitoring his blood sugar level. Resident 26 added that he also had his own continuous blood sugar monitoring device, Dexcom G6. Resident 26 was able to show the transmitter device placed on his abdomen which was covered with a dressing. Review of the Dexcom G6 manual instructions dated 3/2022 showed a warning for a failure to use the machine and its components according to the instructions for use and all indications, contraindications, warnings, precautions, and cautions may result in the resident missing a severe hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) occurrence and/or making a treatment decision may result in injury. The instructions included to clean the insertion site with alcohol wipes to prevent infections. The insertion of the sensor monitor can cause infection, bleeding, or pain, and there is a chance a sensor wire could break or detach and remain under the skin. Medical record review for Resident 26 was initiated on 2/24/25. Resident 26 was admitted to the facility on [DATE], with a diagnosis of diabetes mellitus (a group of diseases that resulted in too much sugar in the blood). (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 02/27/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 26's Order Summary Report dated 2/25/25, showed a physician's order dated 7/15/24, to administer Novolin R solution (fast acting insulin) solution per sliding scale subcutaneously before meals and at bedtime for DM as follows: if blood sugar level 71 to 200 mg/dl, no insulin; if blood sugar level 201 to 250 mg/dl, give 6 units of insulin; if blood sugar level 251 to 300 mg/dl, give 8 units of insulin; if blood sugar level 301 to 350 mg/dl, give 10 units of insulin; if blood sugar level 351 to 400 mg/dl, give 12 units of insulin, and if blood sugar level 401 to 1000 mg/dl, give 15 units of insulin, recheck after one hour and if blood sugar level more than 401 mg/dl to notify the Medical Doctor. However, there was no physician's order for the use of the blood glucose monitoring device, Dexcom G6 and care for the monitor probe placed on the resident's skin. Further review of Resident 26's medical record failed to show documented evidence the use of the blood glucose monitoring device, Dexcom G6. Review of Resident 26's plan of care showed a care plan problem dated 7/15/24, addressing Resident 26's risk of low blood sugar due to DM. However, the plan of care failed to show documented evidence a care plan problem was developed to address Resident 26's use of blood glucose monitoring device. On 2/25/25 at 0938 hours, an observation and concurrent interview was conducted with Resident 26. Resident 26 was observed sitting in his chair. Resident 26 stated he changed by himself the transmitter probe placed on his abdomen every 10 days. Resident 26 stated the facility staff were aware about his blood sugar monitoring device and acknowledged the facility staff were not taking care of his device because he did it by himself. On 2/25/25 at 1426 hours, an interview and concurrent medical record review for Resident 26 was conducted with LVN 2. LVN 2 verified Resident 26 had his own blood sugar monitoring device and the resident took care of the device. LVN 2 was asked if there was a physician's order and care plan was formulated for the use of Resident 26's blood sugar monitoring device. LVN 2 verified there was no physician's order and care plan for Resident 26's use of blood sugar monitoring device, Dexcom G6. On 2/26/25 at 0933 hours, an interview and concurrent medical record review for Resident 26 was conducted with the DON. The DON stated the facility staff would ask the resident who had their own blood sugar monitoring devices to check and monitor for the use of the device as per the physician's order. The DON was informed about Resident 26's own blood sugar monitoring device attached to the resident. The DON verified and acknowledged there was no documentation regarding Resident 26's personal blood sugar monitoring device in the resident's medical record. The DON stated the licensed nurses should have been assessed and documented the resident's own blood sugar monitoring device upon admission and communicated to the physician and obtained an order; care planed; and communicated to other licensed nurses to continue to monitor and provided care. 2. Review of the facility's P&P titled Admission Assessment and Follow up: Role of the Nurse dated 9/2024 showed upon admission, the residents' information was gathered about the resident's physical, emotional, cognitive, and psychosocial condition to manage the resident and completing the required admission assessment. In addition, the nurse would reconcile the list of medications, admitting orders and discharge summary from previous institution. The P&P also showed to contact the Attending Physician to communicate and review the findings of initial assessment and any other pertinent information. (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 02/27/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 293 was initiated on 2/25/25. Resident 293 was admitted to the facility on [DATE]. Review of Resident 293's H&P examination dated 2/7/25, showed Resident 293 had a diagnosis of Chronic Diastolic Heart Failure. Review of Resident 293's Physician's Transfer Orders and CHF Discharge Instruction dated 2/5/25, from the acute care hospital showed to track the weight of Resident 293 daily and the resident was on fluid restriction of 2,000 ml per day. Review of Resident 293's Order Summary Report dated 5/25/25, failed to show a physician's order was obtained for the monitoring of the daily weight and fluid restriction for Resident 293. Further review of Resident 293's medical record failed to show documented evidence the attending physician was notified and informed about Resident 293's transfer orders and instruction from the acute care hospital when Resident 293 was admitted to the facility. On 2/26/25 at 1504 hours, an interview and concurrent medical record review for Resident 293 was conducted with RN 1. RN 1 stated the admission nurse was responsible for the assessment of the residents, review the transfer orders from the acute care hospital, and communicate to the attending physician about the transfer orders. RN 1 was asked about Resident 293's transfer orders and instructions. RN 1 verified Resident 293's diagnosis of CHF and with the instructions from the acute care hospital. RN 1 acknowledged there was no documentation the attending physician was made aware by the admission nurse about the transfer instruction from the acute care hospital. RN 1 reviewed Resident 293's medical record and verified there were no physician's order and progress notes documented by the attending physician regarding the daily weight and fluid restriction. On 2/27/25 at 1000 hours, an interview and concurrent medical record review for Resident 293 was conducted with the DON. The DON stated the admission nurse would assess the resident, review all the transfer orders, and instruction, and communicate to the attending physician. The DON was informed about Resident 293's transfer orders and instructions. The DON acknowledged and verified the transfer orders and instruction for the resident from the acute care hospital. The DON verified and acknowledged the findings. 48882 3. Review of the facility's P&P titled Acute Condition Changes- Clinical Protocol revised 12/2024 showed during the initial assessment, the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the physician. Medical record review for Resident 8 was initiated on 2/24/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of Influenza, COPD, and dependence on supplemental oxygen. Review of Resident 8's H&P examination dated 12/21/24, showed Resident 8 had no capacity to understand and make decisions. (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 02/27/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 received the oxygen therapy and required non-invasive mechanical ventilator while at the facility. Review of Resident 8's Order Summary Report for December 2024 showed the following physician's orders dated 7/31/24: - to administer continuous oxygen every shift via nasal canula at three to four liters per minute to maintain the oxygen saturation level greater than 92% due to CHF; - to check the oxygen saturation level routinely to keep the oxygen saturation level above 92% every shift; - to monitor the oxygen saturation level every hour to ensure safety and comfort; and - to check the oxygen saturation level as needed. Review of Resident 8's MAR for December 2024 showed the following entries: - for the monitoring for the oxygen saturation level every hour to ensure safety and comfort, it was documented on 12/15/24, as follows: * at 0800, 0900, and 1000 hours, the oxygen saturation level was 92%; * at 1100, 1200, and 1300 hours, the oxygen saturation level was 91%; and * at 1400 hours, the oxygen saturation level was 90%. - for the checking of the oxygen saturation routinely to keep the oxygen saturation level above 92% every shift, it was documented on 12/15/24, as follows: * 92% oxygen saturation level for the day shift. Review of Resident 8's Weights and Vitals Summary from 12/13/24 to 12/15/24, showed the following oxygen saturations levels documented: - on 12/15/24 at 0040 hours, 96% on CPAP; - on 12/15/24 at 0917 hours, 92% on oxygen via the nasal canula; - on 12/15/24 at 1009 hours, 91% on oxygen via the nasal canula; - on 12/15/24 at 1300 hours, 84% on oxygen via the nasal canula; - on 12/15/24 at 1313 hours, 90% on oxygen via the nasal canula; and - on 12/15/24 at 1353 hours, 96% on high flow oxygen. (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 02/27/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's SBAR Communication Form and Progress Note dated 12/15/25, showed Resident 8 had a change of condition for non-productive cough and lethargy. The SBAR showed Resident 8's change on condition started on 12/15/25 at 1200 hours. The document showed Resident 8's oxygen saturation level was 90 % via the nasal cannula obtained on 12/15/25 at 1313 hours. Review of Resident 8's Progress Notes dated 12/15/24, showed at 1312 hours, the physician was informed per Resident 8's family member when Resident 8 was noted to be more lethargic and with some intermittent coughs. The vital signs were documented as BP of 126/64 mmHg, HR of 70 beats per minute, RR of 17 breaths per minute, and oxygen saturation level of 90%. Further review of Resident 8's Progress Notes failed to show any documentation Resident 8's oxygen saturation level was rechecked or any documentation of the nursing interventions when Resident 8's oxygen saturation levels were documented at 91% and 92% on 12/15/24 from 0800 to 1200 hours. On 2/26/25 at 1312 hours, an interview and concurrent medical record for Resident 8 was conducted with RN 1. RN 1 stated for the residents with a physician's order to monitor the oxygen saturation level to keep above 92%, and if the resident's oxygen saturation level was 91 or 92% and outside of the resident's baseline, that was considered a change in condition. RN 1 stated the licensed nurse should have evaluated the resident, rechecked the resident's oxygen saturation level, and documented any interventions implemented and reassessment after. RN 1 further stated upon retaking the resident's oxygen saturation level and the oxygen saturation level was 92% or lower, the nurse should have informed the physician and documented in the progress notes. RN 1 reviewed Resident 8's medical record and verified the above findings. RN 1 stated there was no documentation showing Resident 8's oxygen saturation level at 91 to 92% was addressed until Resident 8's family member informed the staff of Resident 8's condition. On 02/27/25 at 1016 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON stated the oxygen saturation level was checked every shift, unless specified by the physician. The DON stated an abnormal oxygen saturation level was when it was below 90% or outside of the resident's baseline. When asked, the DON stated if the physician's order was to check the oxygen saturation level to keep the oxygen saturation level greater than 92 %, for the resident's oxygen saturation level documented at 92%, the DON expected the nurse to reevaluate the resident's oxygen saturation level and document the reevaluated oxygen saturation level. The DON stated if the oxygen saturation level remained at 92%, she expected the nurse to do further evaluation/assessment of the resident, inform the physician, and document in the progress notes. The DON reviewed Resident 8's medical record and verified the above findings. The DON stated for Resident 8's oxygen saturation level of 92%, Resident 8's medical record failed to show a documentation that it was addressed until the change in condition occurred when the resident's family member had informed the nurse. The DON acknowledged the change in condition could have been addressed sooner. On 2/27/25 at 1040 hours, a follow-up 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: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 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** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one of 14 final sampled residents (Resident 33), and two nonsampled residents (Residents 292 and 293). * The facility failed to ensure the PICC line external catheter baseline measurements were obtained and documented for Resident 292. * The facility failed to ensure the PICC line external catheter baseline measurements were obtained and documented for Resident 293. * The facility failed to ensure Resident 33's PIV site was labeled with the date, time, and licensed nurse's initials. These failures had the potential to delay the identification of intravenous catheter related complications for the residents. Findings: 1. Review of the facility's P&P titled Central Venous Catheter Dressing Changes dated 4/2024 showed the dressing of the central venous catheter is routinely changed at least five to seven days or as needed when the dressing becomes wet, soiled, or not intact. The licensed nurse would document the condition of the central venous catheter insertion site, any complications, and interventions that were done. a. Medical record review for Resident 292 was initiated on 2/25/25. Resident 292 was admitted to the facility on [DATE]. On 2/24/25 at 0837 hours, Resident 292 was observed in bed with a family member at the bedside. Resident 292 stated he had an infection in the blood and needed an IV antibiotic medication. Resident 292 stated he had a PICC line on the left upper arm and showed his PICC line with the transparent dressing. The PICC line dressing was observed with a label dated 2/22/25. Resident 292's family member stated the nurse changed the dressing on the PICC line several times. Review of Resident 292's Order Summary Report showed a physician's order dated 2/16/25, to measure the midline external catheter and arm circumference every seven days. However, Resident 292's medical record failed to show the baseline measurement of the length of the external catheter and arm circumference above the insertion site were obtained upon admission. On 2/25/25 at 1137 hours, an interview and concurrent medical record review for Resident 292 was conducted with LVN 2. LVN 2 verified Resident 292 had a PICC line on the left upper arm. LVN 2 stated the RNs were responsible for the care and maintenance of the PICC lines. (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 02/27/2025
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Medical record review for Resident 293 was initiated on 2/25/25. Resident 293 was admitted to the facility on [DATE]. On 2/24/25 at 0822 hours, Resident 293 was observed lying in bed with a PICC line on the right upper arm with a transparent dressing in placed and dated 2/20/25. Resident 293 stated he had a surgery on his foot and was on the IV antibiotic medications. Review of Resident 293's Order Summary Report showed a physician's order dated 2/5/25, to monitor the IV PICC on the RUE every shift and to administer ertapenem sodium injection solution reconstituted (antibiotic medication) 500 mg intravenously via PICC line in the morning for osteomyelitis of the right foot at 1000 hours, for 41 days. However, Resident 293's medical record failed to show the baseline measurements of the length of the external catheter and arm circumference above the insertion site were obtained upon admission. On 2/26/25 at 1143 hours, an interview and concurrent medical record review for Residents 292 and 293 was conducted with RN 1. RN 1 stated the admission nurse was responsible for the assessment of the residents who had a PICC or central line upon admission. RN 1 stated they usually changed the PICC line dressing on the following day after the admission and they measured the length of the external catheter and arm circumference of the resident. RN 1 was asked on how she would know if there were any changes to the measurements of the length of the catheter and arm circumference. RN 1 stated she would compare the measurements from the previous measurements to know if there were any changes. RN 1 was asked if there were a baseline measurements of the length of the external catheter and arm circumference for Residents 292 and 293 obtained upon admission. RN 1 reviewed Residents 292 and 293's medical records and verified there were no baseline measurements of the length of the external catheter and arm circumference for Residents 292 and 293. On 2/27/25 at 0955 hours, an interview and concurrent medical record review for Residents 292 and 293 was conducted with the DON. The DON stated she expected the resident's central line should have been properly cared and maintained upon admission. The DON stated the licensed nurses and RNs were responsible for providing care of the central lines. The DON stated the assessment of the central line would be documented in the residents' medical record. The DON was informed and verified the above findings. 48882 2. Review of the facility's P&P titled Peripheral IV Dressing Changes dated 5/2022 showed to change the dressing at the time of the catheter site rotation (every 72 to 96 hours) or immediately upon observing that the integrity of the dressing has been compromised. To place a new transparent semi-permeable membrane dressing over the insertion site and to label the peripheral IV dressing with the date, time, and initials. Medical record review for Resident 33 was initiated on 2/24/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's H&P examination dated 1/29/25, showed Resident 33 had no capacity to understand and make decisions. (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 02/27/2025
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's Order Summary Report showed a physician's order dated 2/22/25, to administer levofloxacin (antibiotic medication) 250 mg intravenously daily for urinary tract and ESBL in the urine. Review of Resident 33's Progress Notes showed a Daily Nurses Note on 2/21/25 at 1702 hours, showing the insertion of the PIV to Resident 33's left forearm. On 2/24/25 at 0923 hours, an observation and concurrent interview was conducted with LVN 1. Resident 33 was observed with a PIV to the right arm. The dressing of the right arm's PIV site was not observed labeled with the date, time, and initial of the staff who inserted the PIV. LVN 1 verified the above findings and stated the PIV dressing should be labeled with the date to ensure the facility staff were aware when the PIV was inserted or when the PIV dressing was last changed. On 2/24/25 at 0935 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 33's right arm PIV dressing did not have a date. RN 1 stated the PIVs were changed every 72 hours and may be extended (with a physician's order) for seven days if the resident had poor venous access. RN 1 further stated Resident 33's PIV was due to be changed today. On 2/25/25 at 1519 hours, a follow-up interview and concurrent medical record review for Resident 33 was conducted with RN 1. RN 1 stated the PIV site and insertion date should be documented in the residents IV Administration Record and progress notes to ensure communication to the other shifts regarding when the PIV was placed and when it needed to be changed. When RN 1 was asked when Resident 33's right arm PIV was placed, RN 1 reviewed Resident 33's medical record and stated there was no documentation in Resident 33's medical record to show when the right arm PIV was inserted. On 2/27/25 at 1016 hours, an interview was conducted with the DON. The DON stated upon the insertion of the PIV, the nurse was expected to label the PIV dressing with the date and initial. The DON further stated the nurse was expected to document the insertion of the resident's new PIV including the site in the IV Administration Record and nursing progress notes. On 2/27/25 at 1040 hours, a follow-up 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: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 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** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the safe respiratory care services for two of four final sampled residents (Residents 8 and 294) reviewed for the respiratory care. * The facility failed to ensure Resident 8's non-invasive ventilator machine was cleaned as per the manufacturer's guidelines and the headgear and tubing were cleaned as per the facility's P&P. * The facility failed to ensure Resident 294's CPAP machine was cleaned as per the manufacturer's guidelines and failed to ensure the mask with straps and tubing were placed in the clear plastic bag when not in used. These failures had the risk for equipment contamination and respiratory complications, which might adversely affect the health and well-being of Residents 8 and 294. Findings: Review of the facility's P&P titled CPAP/BiPAP P&P revised 12/2024 showed to review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the machine. Under the general guidelines for cleaning showed the following: - Machine cleaning: to wipe the machine with soapy water and rinse at least once a week and as needed. - Humidifier (if used): use clean, distilled water only in the humidifier chamber; to clean the humidifier weekly and air dry; and to disinfect using vinegar-water solution (1:3) in the clean humidifier. To soak for 30 minutes and rinse thoroughly. - Filter cleaning: to rinse the washable filter under running water once a week to remove dust and debris. - Mask and nasal pillows: to wipe with isopropyl alcohol daily after use. - Tubings and headgear (strap): to wash with soapy water, rinse, and air dry weekly. 1. Review of the facility's document titled ResMed Astral series (CPAP machine) user guide dated 5/2018 under the cleaning and maintenance section showed a [resident] treated by mechanical ventilation is highly vulnerable to the risks of infection. Dirty or contaminated equipment is a potential source of infection. To clean the exterior surfaces of the Astral device with a damp cloth using mild cleaning solution. To inspect the condition of the air filter and check whether it is blocked by dirt or dust. With normal use, the air filter needs to be replaced every six months (or more often in a dusty environment). CAUTION: do not wash the air filter. The air filter is not washable or reusable. (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 02/27/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 8 was initiated on 2/24/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of COPD and dependence on supplemental oxygen. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 received oxygen therapy and required non-invasive mechanical ventilator at the facility. Review of Resident 8's Plan of Care showed a care plan problem dated 1/28/25, addressing Resident 8's risk for ineffective airway exchange/chest congestion, shortness of breath secondary to COPD. The interventions showed to administer the non-invasive ventilator machine at bedtime with settings of: min EPAP 5.0, max EPAP 10.0, min P 5 cm H2O 5.0, max P5 cm H2O 18.0, auto EPAP on every night shift, related to COPD. However, further review of the care plan failed to show the interventions for the care and maintenance of Resident 8's BiPAP device and equipment. Review of Resident 8's Order Summary Report showed the following physician's orders: - dated 12/19/24, for the non-invasive ventilator machine, to change the filter as needed for excessive soilage; - dated 1/28/25, to apply the non-invasive ventilator machine at bedtime with the following setting: minimum EPAP 5.0, maximum EPAP 10.0. minimum P 5 cm H2O 5.0, maximum P 5 cm H2O 18.0, auto EPAP on every night shift related to COPD and monitor the number of hours in use; - dated 2/8/25, to wash the headgear and tubing with soap and water and air dry every day shift on Saturdays; and - dated 2/26/25, for the cleaning of the filter, to rinse the washable filter under running water once a week to remove the dust and debris and every day shift on Saturdays. Review of Resident 8's TAR for February 2025 showed the following: - dated 1/30/25, for an order clarification to wash the headgear and tubing with soap and water and air to dry every Thursday and wash every day shift on Thursdays. The record showed it was washed on 2/6/25, during the day shift. - dated 2/15/25, for an order clarification to wash the headgear and tubing with soap and water and air to dry every Thursday and wash every day shift on Saturdays. There was no documentation the headgear and tubing were washed. Further review of Resident 8's TAR failed to show the documentation the non-invasive ventilator device was cleaned, or the filter was checked. On 2/27/25 at 0725 hours, Resident 8 was observed sleeping in bed. Resident 8 was observed with the mask and headgear applied and the ResMed BiPAP machine on. (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 02/27/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 0816 hours, Resident 8 was observed in bed receiving oxygen at three liters per minute via the nasal cannula. Resident 8's nasal cannula tubing was observed connecting to the oxygen concentrator with the nasal cannula tubing observed touching the ground. Additionally, Resident 8's BiPAP headgear and mask were observed inside a clear plastic bag; however, the oxygen tubing connected to the BiPAP mask was observed hanging out of the plastic bag and the tubing touching the ground. On 2/27/25 at 0821 hours, an observation, interview and concurrent medical record review for Resident 8 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the nasal cannula tubing and BiPAP oxygen tubing should not touch the ground. Additionally, LVN 1 verified Resident 8 used the BiPAP machine at bedtime and continuous oxygen at three liters per minute via the nasal cannula during the day. LVN 1 stated the night shift nurses or day shift nurses were responsible for removing Resident 8's headgear and mask in the morning and placed the mask, head gear, and tubing in a clear plastic bag. When asked, LVN 1 stated Resident 8's headgear and mask were cleaned by the morning nurse every Saturday and documented in the TAR. When asked about the cleaning of the BiPAP machine, LVN 1 stated she was not sure and did not touch the machine. When asked when the BiPAP machine was last cleaned, LVN 1 was unable to provide the documentation for the cleaning of Resident 8's BiPAP machine. When asked about the last time Resident 8's BiPAP headgear, tubing, and mask were last cleaned, LVN 1 reviewed Resident 8's medical record and verified the BiPAP headgear, tubing, and mask were cleaned on 2/6/25, more than a week ago. On 2/27/25 at 1016 hours, an interview was conducted with the DON. The DON stated for the residents on CPAP/BiPAP, the cleaning of the CPAP/BiPAP device as well as the headgear, mask, and tubing were done by the treatment nurse every Saturday and documented in the TAR. The DON further stated the CPAP/BiPAP devices should be cleaned as per the user guide to ensure the proper care and maintenance of the device. On 2/27/25 at 1040 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39670 2. On 2/24/25 at 1038 hours and 2/25/25 at 0808 hours, an observation and concurrent interview was conducted with Resident 294. Resident 294 was observed in bed with the CPAP machine at the bedside drawer, the mask placed on top of the drawer, and the tubing was touching the floor. Resident 294 stated she put the CPAP mask on her face and the staff assisted her on putting the strap at the back of her head. Resident 294 added the staff did not need to do anything on the machine, she just turned on by herself and turned off and take it off after she used. Review of the ResMed AirSence 10 (CPAP machine) user guide (undated) showed under the caring for the device section, to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health; and clean the device weekly as directed. Medical record review for Resident 294 was initiated on 2/25/25. Resident 294 was admitted to the facility on [DATE]. Review of Resident 294's Plan of Care showed a care plan problem dated 2/9/25, addressing Resident 294's problem of sleep disorder. The interventions included to clean the CPAP machine. (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 02/27/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 294's Order Summary Report dated 2/25/25, showed the following physician's orders for the care of the CPAP machine: - dated 2/7/25, to change the CPAP filter as needed for excessive soilage - dated 2/9/25, to wash the CPAP headgear and tubing with soap and water and air to dry every Saturday. However, there was no physician's order obtained to clean the CPAP device weekly as directed by the user's guide. On 2/25/25 at 1417 hours, an interview for Resident 294 was conducted with CNA 7. CNA 7 stated Resident 294 asked for assistance to have the CPAP put on her. CNA 7 stated the licensed nurses were responsible for the cleaning of the CPAP machine. On 2/25/25 at 1432 hours, an interview and concurrent medical record review for Resident 294 was conducted with LVN 2. LVN 2 stated Resident 294 did not want anyone to touch her machine and very independent. LVN 2 was informed of the observation of the CPAP machine mask and tubing were placed on top of the drawer with the tubing touching the floor. LVN 2 acknowledged the CPAP machine mask and tubing should be placed in the clear plastic bag when not in use. LVN 2 stated the night nurses were responsible for cleaning the machine. On 2/26/25 at 1314 hours, an interview and concurrent medical record review for Resident 294 was conducted with the DON. The DON stated she expected the licensed nurses to be responsible for the cleanliness and functionality of the devices used by the residents. The DON was asked about Resident 294's CPAP machine use and informed her about the observation of the resident's CPAP at the bedside drawer with the mask with strap was on top of the drawer and the tubing was on the floor. The DON stated she expected the CPAP machine mask and tubing should have been placed in the clear plastic bag when not in use. The DON was asked about the cleaning and maintenance of the CPAP machine. The DON stated they cleaned the facemask with the strap once a week and as needed. The DON reviewed the physician's orders and was able to show the order for cleaning of the CPAP strap and tubing on Saturdays, however, when asked if there was a specific physician's order for the cleaning of the CPAP machine device, the DON acknowledged there was no physician's order. The DON verified there was a cleaning instructions per the user guide of the CPAP machine and acknowledged they did not follow the cleaning instruction as per the manufacturer's user guide. The DON verified there was no documentation on the TAR regarding the cleaning of the CPAP machine.		

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 02/27/2025
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 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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medications as evidenced by: * LVN 2 failed to administer Resident 542's dexamethasone (steroid, anti-inflammation medication) as per the physician's order. This failure had the potential to negatively affect Resident 542's health condition, for possible complications. Findings: Review of the facility's P&P titled Administering Medications revised 4/2024 showed the medications are administered in accordance with the prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified. On 2/25/25 at 0906 hours, a medication administration observation for Resident 542 was conducted with LVN 2. LVN 2 prepared and administered Resident 542 the following medications: - one-half tablet of dexamethasone 1 mg; - one tablet of atorvastatin (anticholesterol) 10 mg; - one table of hydralazine (antihypertensive) 50 mg; - one tablet of jardiance (antidiabetic) 10 mg; - one tablet of felodipine (antihypertensive) ER 10 mg; - one tablet of levetiracetam (anticonvulsant) 1000 mg; - one tablet of lacosamide (anticonvulsant) 100 mg; - one table of metoprolol (antihypertensive) 25 mg; - one tablet of losartan (antihypertensive) 100 mg; and - one injection of enoxaparin (anticoagulant) 40 mg. Medical record review for Resident 542 was initiated on 2/25/25. Resident 542 was admitted to the facility on [DATE]. Review of Resident 542's Order Summary Report showed a physician's order dated 2/22/25, for dexamethasone 1 mg one-half tablet by mouth in the morning every other day. The order further showed to take the medication with breakfast. (continued on next page)		

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

Printed: 05/28/2025
Form Approved OMB
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 02/27/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 0927 hours, an interview and concurrent medical record review for Resident 542 was conducted with LVN 2. LVN 2 verified Resident 542's dexamethasone medication 1 mg one-half tablet every other day was scheduled to be administered at 0715 hours, with breakfast. LVN 2 stated Resident 542's breakfast was served at 0815 hours on 2/25/25. LVN 2 verified the dexamethasone medication was administered late, not administered with breakfast as per the physician's order. On 2/27/25 at 1040 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: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility review, the facility failed to ensure three of five final sampled residents (Residents 27, 33, and 36) reviewed for the unnecessary medications were free from the unnecessary psychotropic drugs. * The facility failed to ensure Resident 33's orthostatic blood pressure was monitored as ordered by the physician related to the use of the sertraline (antidepressant) medication. * The facility failed to ensure Resident 36's orthostatic blood pressures were accurately monitored for the use of the Seroquel (antipsychotic medication), bupropion (antidepressant medication), and desvenlafaxine (antidepressant medication); the facility failed to document the implementation of the non-pharmacological interventions for Resident 36's use of the Seroquel, bupropion, desvenlafaxine, and Depakote(mood stabilizer) medications. In addition, the facility failed to accurately monitor the specific behavior manifestation for Resident 36's use of the Seroquel medication. * The facility failed to ensure Resident 27 was properly monitored for orthostatic blood pressures as ordered by the physician for the use of the olanzapine (a medication for mental disorders including schizophrenia and bipolar disorder). These failures had the potential for the residents to have adverse complications from the medications and the potential of not providing the correct data to the prescriber in order to adjust the dose of the psychotropic medications for the residents. Findings: Review of the facility's P&P titled Antipsychotic Medication Use revised 3/2024 showed the staff will observe, document, and report to the Attending Physician/psychiatrist information regarding the effectiveness of any interventions, including antipsychotic medications. The nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medication to the Attending Physician/psychiatrist: b. Cardiovascular: orthostatic, arrhythmias 1. Medical record review for Resident 33 was initiated on 2/24/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's H&P examination dated 1/29/25, showed Resident 33 had no capacity to understand and make decisions. (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's Order Summary Report dated 2/25/25, showed a physician's order dated 1/25/25, to administer sertraline 50 mg one tablet by mouth daily for the verbalization of feeling sad, and to monitor the side effects of the sertraline medication such as sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, and orthostatic hypotension every shift. Review of Resident 33's MAR for February 2025 showed the following: - Resident 33 was administered sertraline 50 mg one tablet by mouth daily from 2/1 to 2/25/25 at 0900 hours, and - Resident 33 was monitored for the side effects from the sertraline medication usage such as sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, and orthostatic hypotension. However, the MAR showed, - from 2/1 to 2/24/25, for the day, evening, and night shifts. However, further review of Resident 33's MAR failed to show the documentation of the BP readings for Resident 33's orthostatic hypotension monitoring related to the use of the sertraline medication. Review of Resident 33's Plan of Care showed a care plan problem dated 1/25/25, addressing Resident 33's tendency towards depression as manifested by the verbalization of feeling sad. The interventions included to monitor the side effects of the sertraline medication usage such as sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, and orthostatic hypotension. On 2/26/25 at 1337 hours, an interview and concurrent medical record review for Resident 33 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the orthostatic hypotension was being monitored by obtaining the resident's blood pressure in three different positions such as sitting, lying, and standing, and comparing the blood pressures to determine if there was a drop in the blood pressure, which would indicate orthostatic hypotension. RN 1 reviewed Resident 33's medical record and stated there was no documentation Resident 33 was monitored for the orthostatic hypotension. On 2/27/25 at 1016 hours, an interview was conducted with the DON. The DON stated for the residents prescribed with antipsychotic medications, the licensed nurses would monitor the residents for the potential side effects related to the antipsychotic medications every shift. When asked, the DON stated the orthostatic hypotension should be monitored by obtaining the resident's blood pressure in different positions such as lying, sitting, and standing. The DON further stated the blood pressure measurements obtained for each position should be documented. On 2/27/25 at 1040 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 36 was initiated on 2/24/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 1/25/25, showed Resident 36 had no capacity to understand and make decisions. (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 36's Order Summary Report dated 2/25/25, showed the following physician's orders for the use of bupropion medication: - dated 1/22/25, to monitor and record the number of depression episode as manifested by verbalization of feeling sad due to the bupropion medication use every shift; - dated 1/22/25, to monitor for the side effects of the bupropion medication: sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, orthostatic hypotension every shift; and - dated 2/21/25, to administer bupropion extended release 150 mg by mouth daily related to major depressive disorder manifested by verbalization of feeling sad. Review of Resident 36's Order Summary Report dated 2/25/25, showed the following physician's orders for the use of the desvenlafaxine medication: - dated 1/22/25, to monitor and record the number of depression episode as manifested by crying spells due to desvenlafaxine use every shift; - dated 1/22/25, to monitor for side effects of the desvenlafaxine medication: sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, orthostatic hypotension every shift; and - dated 2/21/25, to administer desvenlafaxine extended release 50 mg, two tablets by mouth in the morning related to major depressive disorder manifested by crying spells. Review of Resident 36's Order Summary Report dated 2/25/25, showed the following physician's orders for the use of the Depakote medication: - dated 2/1/25, to administer Depakote Delayed Release 250 mg one tablet every 12 hours for mood lability from pleasant to angry outbursts; and - dated 2/1/25, to monitor and record the number of psychotic behaviors as manifested by mood lability from pleasant to angry outburst, every shift. Review of Resident 36's Order Summary Report dated 2/25/25, showed the following physician's orders for the use of the Seroquel medication: - dated 2/10/25, to monitor and record the number of psychotic behaviors as manifested by dementia with behavior disturbances every shift; - dated 2/10/25, to monitor the orthostatic blood pressure lying, sitting, and standing positions due to Seroquel medication use every day shift on Sundays; and - dated 2/19/25, to administer Seroquel 200 mg, one tablet by mouth at bedtime for dementia with behavior disturbances as manifested by aggressive behavior towards staff. (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the physician's orders showed the following orders for non-pharmacological intervention: - dated 1/22/25, to record the non-pharmacological interventions for depression and to document the following: 1- Music/Radio/TV, 2- Activity/Exercise, 3- Redirection/Refocus/Diversion, 4- Removal of stimuli, 5- 1:1 conversation, 6- Verbal cues/Prompting/Encouraging, 7- Reassurance/orientation, 8- Massage, 9- Other, as needed; and - dated 2/10/25, to record the non-pharmacological interventions for psychosis and to document the following: 1- Music/Radio/TV, 2- Activity/Exercise, 3- Redirection/Refocus/Diversion, 4- Removal of stimuli, 5- 1:1 conversation, 6- Verbal cues/Prompting/Encouraging, 7- Reassurance/orientation, 8- Massage, 9- Other, as needed. a. Review of Resident 36's MAR for February 2025 showed the following: - on 2/16/25, the blood pressure readings were documented as 144/85 mmHg for the lying, sitting, and standing positions; and - on 2/23/25, the blood pressure readings were documented as 140/74 mmHg for the lying, sitting and standing positions. For the monitoring of Resident 36 for the side effects from the bupropion medication usage such as sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, orthostatic hypotension, the MAR showed, - from 2/1 to 2/24/25 for the day, evening, and night shifts. For the monitoring of Resident 36 for side effects from the desvenlafaxine medication usage such as sedation, dry mouth, blurred vision, constipation, urinary retention, tachycardia, headache, weight gain, orthostatic hypotension, the MAR showed, - from 2/1 to 2/24/25 for the day, evening, and night shifts. b. Review of Resident 36's MAR for February 2025, showed the following: * Resident 36 had the episodes of depression manifested by the verbalization of feeling sad for the usage of the bupropion medication on the following dates: - on 2/11 and 2/12/25, two episodes during the day shift, and - on 2/19/25, three episodes during the day shift. * Resident 36 had the episodes of depression behaviors manifested by crying spells for the usage of the desvenlafaxine medication as follows: - on 2/11, 2/12, and 2/19/25, two episodes during the day shift, * Resident 36 had the episodes of psychotic behaviors manifested by mood lability from pleasant to angry outbursts as follows: (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 2/12, and 2/19/25, three episodes during the day shift, - on 2/22/25, three episodes during the day, evening, and night shift; and - on 2/23/25, three episodes during the evening shift. * Resident 36 had the episodes of psychotic behaviors manifested by dementia with behavior disturbances as follows: - on 2/12/25, five episodes during the day shift, - on 2/16/25, three episodes during the day shift, and two episodes during the evening shift, - on 2/17/25, one episode during the evening shift, - on 2/18/25, two episodes during the evening shift, - on 2/19/25, three episodes during the day shift and one episode during the evening shift, - on 2/20/25, three episodes during the day and evening shift, - on 2/21/25, three episodes during the evening shift and four episodes during the night shift, - on 2/22/25, six episodes during the day, evening, and night shifts, and - on 2/23/25, seven episodes during the day shift and three episodes during the evening shift. Further review of the MAR failed to show documentation of the non-pharmacological interventions were provided to Resident 36 for the above documented behavioral episodes. On 2/26/25 at 1414 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 1. When asked about the monitoring of orthostatic hypotension, LVN 1 stated the orthostatic hypotension was obtained by taking the resident's blood pressure in the lying, sitting, and standing positions, and comparing the blood pressure measurements to determine if there was a drop in the blood pressure. LVN 1 further stated if there was a drop in the blood pressure due to the position changes, the physician needed to be informed. LVN 1 reviewed Resident 36's MAR for February 2025 and verified the orthostatic blood pressure measurements for the lying, sitting, and standing positions were the same on 2/16 and 2/23/25. (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 1016 hours, an interview and concurrent medical record review for Resident 36 was conducted with the DON. The DON stated for the use of the psychotropic medications, the nurse was responsible for entering the physician's orders, including the orders for the monitoring of the specific behaviors for the use of the psychotropic medication, and the monitoring for side effects related to the use of the medication. The DON stated the nurses were responsible for ensuring the behavior being monitored accurately reflected the behavior the resident was manifesting for the use of the antipsychotic medication. The DON stated every shift, the nurses were responsible for monitoring the resident and recording the number of behaviors the resident was exhibiting related to the use of the antipsychotic medication. The DON further stated if any behaviors were present, the nurses were expected to provide and document the non-pharmacological interventions provided. The DON reviewed Resident 36's medical record and verified the above findings. Additionally, the DON verified Resident 36 was monitored for the behavior disturbances (for the use of the Seroquel medication) instead of the monitoring for the aggressive behavior towards staff as ordered by the physician. On 2/27/25 at 1040 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 49644 3. Medical record review for Resident 27 was initiated on 2/25/25. Resident 27 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 27's H&P examination dated 1/15/25, showed Resident 27 had no capacity to understand and make decisions. Review of Resident 27's Psychiatric Note dated 2/6/25, showed the diagnosis of unspecified psychosis due to a substance or known physiological condition. Review of Resident 27's Order Summary Report dated 2/12/25, showed a physician's orders dated 1/14/25, to monitor the orthostatic BP when lying, sitting, and standing for olanzapine use every Sunday. Review of Resident 27's MARs for January and February 2025, showed the orthostatic BP was scheduled to be monitored every Sunday. However, Resident 27's BP readings for the lying, sitting, and standing were the same as follows on the following: - dated 1/26/25, the BP readings were 118/69 mmHg for the lying, sitting, and standing position; - dated 2/2/25, the BP readings were 107/59 mmHg for the lying, sitting, and standing position; and - dated 2/9/25, the BP readings were 115/62 mmHg for the lying, sitting, and standing position. On 2/27/25 at 0817 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 27's orthostatic BP were the same for the lying, sitting, and standing positions on 1/26, 2/2, and 2/9/25. RN 1 stated Resident 27 should have a different BP readings from different positions. RN 1 further stated there can be a difference on the BP result on lying, sitting or different positions. RN 1 stated the olanzapine medication could cause the blood pressure to drop or orthostatic hypotension. (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 02/27/2025
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 0922 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified above findings. The DON acknowledged the licensed nurse did not do the proper orthostatic BP monitoring for Resident 27. The DON stated the orthostatic BP monitoring should have been done properly to know if there was a significant adverse reaction from olanzapine medication.		

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 02/27/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50953 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: * Seven cups of apple juice and one cup of yogurt were unlabeled and undated inside the walk-in refrigerator. This failure had the potential to result in foodborne illnesses for the residents receiving food prepared in the kitchen. Findings: Review of the facility's document showed 55 of 55 residents receiving food prepared in the kitchen. Review of the facility's P&P titled Labeling/Date Marking and Safe Storage of Refrigerated and Frozen Foods revised 1/1/18, showed to provide a means for the safe storage of refrigerated items that have been opened and may not be in their original container. Any foods removed from original container will be properly labeled as follows: the name of the food item being stored and the date the food was removed from its original container and stored. On 2/24/25 at 0800 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the DSS. Seven cups of apple juice and one cup of yogurt were observed undated and unlabeled inside the walk-in refrigerator. The DSS acknowledged and verified the findings. The DSS stated the kitchen staff prepared the above food items last night and should be labeled and dated. On 2/26/25 at 0843 hours, a follow-up interview was conducted with the DSS. When asked regarding the facility's process when removing the food from the original container, the DSS stated the food removed from the original container needed to be dated and labeled. On 2/27/25 at 1318 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: 555671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. A plan to maximize recruitment and retention of direct care staff; and 4. A contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 2/27/25 at 1042 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with Administrator. The Administrator verified the Facility Assessment was dated 6/6/24, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no resources necessary to care for the residents including weekends, and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.		

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 02/27/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and facility P&P review, the facility failed to perform the hand hygiene and maintain the infection practices to help prevent the development and transmission of diseases and infection. * The Activity Assistant failed to performed hand hygiene after removing the PPE when coming out of Room A with Novel Respiratory Precaution sign. * CNA 7 failed to perform hand hygiene after removing the PPE and leaving Room A. * CNA 1 failed to performed hand hygiene after removing the PPE from answering the call light in Room A. * The facility failed to ensure CNA 8 followed the enhanced barrier precautions for Resident 292 when changing the resident's disposable briefs. These findings failed to prevent the development and transmission of communicable diseases and infections. Findings: Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2022 showed this facility considers hand hygiene the primary means to prevent the spread of infection. Hand hygiene is the final step after removing and disposing of personal protective equipment. On 2/24/25 at 0841 hours, during the initial tour of the facility, Room A had a sign outside the door stop - Novel Respiratory Precaution. 1.a. On 2/25/25 at 0855 hours, an observation and concurrent interview was conducted with the Activity Assistant. The Activity Assistant was observed donning off PPE when leaving Room A and did not perform hand washing and proceeded to go to another resident's room. The Activity Assistant was informed on the findings and stated she should wash her hands after coming out of Room A. b. On 2/25/25 at 1407 hours, an observation was conducted with CNA 7. CNA 7 was observed coming out from Room A, removing the PPE and bringing the soiled barrel in the laundry without hand hygiene and proceeded to answer the call light in room [ROOM NUMBER]. CNA 7 acknowledge the findings, did not perform hand hygiene before answering the call light in room [ROOM NUMBER]. c. On 2/26/25 at 0759 hours, an observation was conducted with CNA 1. CNA 1 was observed answering the call light on Room A. CNA 1 was observed removing her PPE and putting another pair of gloves without hand washing. On 2/26/25 at 0822 hours, an interview was conducted with CNA 1. CNA 1 verified she did not perform hand hygiene when she answered the call light and put another pair of gloves in Room A. (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 02/27/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 0803 hours, an interview was conducted with the DSD. The DSD was informed of the above findings. The DSD stated hand washing before and after PPE use would prevent transmission of disease and infection control. On 2/27/25 at 1318 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 39670 2. On 2/25/25 at 0826 hours, an observation and concurrent interview for Resident 294 was conducted with CNA 8. Resident 294 was observed in bed being assisted by CNA 8 to change the resident's soiled disposable briefs. CNA 8 was observed not wearing a gown. A posted signage was observed at Resident 294's doorway indicating Resident 294 was on enhanced barrier precaution, and the staff must wear a gown and gloves when providing high contact resident care such as changing incontinent briefs or assisted in toiletry. CNA 8 was asked about the resident and stated the resident needed assistance for changing the disposable briefs for incontinent episodes. CNA 8 was asked about the resident's isolation precaution. CNA 8 stated she was told by the charge nurse that Resident 294 was not on any isolation precaution anymore, so she did not wear a gown when providing care to the resident. CNA 8 was asked what the posted signage on the doorway of the resident was. CNA 8 acknowledged the room was on enhanced barrier precaution and she should wear a gown when providing the care to the resident. Medical record review for Resident 292 was initiated on 2/25/25. Resident 292 was admitted to the facility on [DATE]. Review of Resident 292's Order Summary Report showed a physician's order dated 2/17/25, to place Resident 292 on an enhanced barrier precaution due to the presence of the left upper extremity midline every shift. Review of Resident 292's Plan of Care showed a care plan problem dated 2/9/25, addressing the enhance barrier precaution. The interventions included to wear a gown and gloves within the room before high contact care activities; and remove and discard the PPEs in regular trash bins when the activity was completed before leaving room. On 2/25/25 at 1137 hours, an interview and concurrent medical record review for Resident 294 was conducted with LVN 2. LVN 2 verified Resident 294 was on the enhanced barrier protection due to Resident 294 had a PICC line on the left upper arm. LVN 2 was asked what the staff should do when providing the care including changing the soiled disposable brief to the resident on the enhanced barrier protection and . LVN 2 stated the CNA should wear a PPE such as gloves and gown when in contact with the resident such as changing the disposable briefs. On 2/27/25 at 0955 hours, an interview for Resident 294 was conducted with the DON. The DON was asked about the residents who were on enhanced barrier precaution. The DON stated she expected all the facility staff should be aware and knowledgeable about the residents who were placed on the enhanced barrier precaution. The DON was informed and acknowledged the above findings.		

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 02/27/2025
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 0883 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the pneumococcal immunization was offered and administered to one nonsampled residents (Resident 15) reviewed for pneumococcal immunization. This failure placed the residents at risk to acquire pneumococcal infection (also known as pneumococcal disease, is caused by the bacteria Streptococcus pneumoniae, or pneumococcus). Findings: Review of the facility's P&P titled Pneumococcal Vaccine revised 10/2019 showed all the residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Review of the Pneumococcal Conjugate Vaccine: What You Need to Know vaccine information sheet dated 5/12/23, showed pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are three pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20). The different vaccines are recommended for different people based on the age and medical status. Adults [AGE] years or older who have not previously received pneumococcal conjugate vaccine should receive pneumococcal conjugate vaccine. Closed medical record review for Resident 15 was initiated on 1/30/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Immunization Record showed Resident 15 received Pneumonia 23 vaccine on 6/1/15. However, the Immunization Record did not show documented evidence of the administration of the pneumococcal conjugate vaccine. Review of Resident 15's Physician Progress Note dated 7/4/24, showed Resident 15 had encephalopathy (a disturbance of brain function). On 2/27/25 at 1039 hours, an interview and concurrent closed medical record review was conducted with the IP. When asked about the immunization process, the IP stated the admitting nurse would offer the PCV20 vaccine upon admission, notify the physician, and obtain an order to administer the vaccine. The IP verified Resident 15 received Pneumonia 23 vaccine on 6/1/15, and the pneumococcal conjugate vaccine was not given. The IP stated the admitting nurse should have offered the PCV20 vaccine to Resident 15. On 2/27/25 at 1126 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the pneumococcal conjugate vaccine should have been offered again to Resident 15.		