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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure proper medication storage for one of one medication carts (Medication Cart A) and one of two medication rooms (Medication Room A). * The facility failed to ensure inhalation solution vials were stored in the foil pouch, and labeled with opened date in Medication Cart A. * The facility failed to ensure an oral alendronate (bisphosphonates, prevent bone breakdown and increase bone density) medication was not stored with cyclosporine ophthalmic emulsion (immunomodulators, works by decreasing swelling in the eye to allow for tear production) eyedrops and glucometer control solutions in Medication Cart A. * The facility failed to ensure a bottle of Tubersol (tuberculin purified protein derivative) and latanoprost eyedrops (prostaglandin analogs, lowers pressure in the eye by increasing the flow from the eye) were labeled with opened date in Medication Room A. * The facility failed to ensure the label on the diclofenac (nonsteroidal anti-inflammatory drug, used to treat mild to moderate pain) medication for Resident 4 matched the physician's order. * The facility failed to ensure the label on the baclofen (skeletal muscle relaxant used primarily to treat reversible spasticity) bubble pack medication for Resident 59 matched the physician's order. These failures had the potential to affect the potency of the medications, also potential for the licensed nurses to administer medications inaccurately and posed the risk for the occurrence of errors in medication administration.Findings: 1. Review of the drug label information for budosenide inhalation updated 2/2/26, showed it is supplied in sealed foil envelopes and when an envelope has been opened, the shelf life of the unused ampules is two weeks when protected. After opening the aluminum foil envelope, the unused ampules should be returned to the aluminum foil envelope to protect them from light. Review of the drug label information for ipratropium bromide and albuterol solution updated 1/11/24, showed to store in pouch until time of use. On 2/17/26 at 1522 hours, an inspection of Medication Cart A was conducted with RN 3. The following was observed: - two unit-dose vials of budesonide were not stored in the foil pouch; - two unit-dose vials of ipratropium bromide and albuterol solution were not stored in the foil pouch; and - a box of alendronate sodium was stored with cyclosporine ophthalmic emulsion and the glucometer control solutions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 3 verified the above findings. 2. Review of the drug label information for Tubersol updated 1/25/24, showed a vial of Tubersol which has been entered and in use for 30 days should be discarded. Review of the drug label information for latanoprost solution updated 9/15/24, showed once a bottle is opened for use, it may be stored at room temperature for six weeks On 2/20/26 at 0821 hours, an inspection of Medication Room A was conducted with RN 2. The following was observed - an opened Tubersol solution without an opened date; and - an opened latanoprost eyedrops without an opened date. RN 2 verified the above findings. 3. Review of the facility's P&P titled Storage of Medications revised 5/2025 showed the following: - drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing; and - hazardous drugs are clearly marked and stored separately from other medications. Review of the facility's P&P titled Labeling of Medications revised 4/2025 showed any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. On 2/19/26 at 0758 hours, a medication administration observation for Resident 4, interview and concurrent medical record review was conducted with LVN 5. While LVN 5 was preparing Resident 4's medications, Resident 4's tube of diclofenac was observed with the following pharmacy label: diclofenac sodium 1% gel apply two grams to left elbow and left knee topically four times a day for pain management. Medical record review for Resident 4 was initiated on 2/17/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 28's Order Summary Report showed physician's orders dated 3/11/25: - to administer diclofenac sodium external gel 1% apply to left elbow topically four tumes a day for pain management, apply two grams; - to administer diclofenac sodium external gel 1% apply to left knee topically four tumes a day for pain management, apply four grams; - to administer diclofenac sodium external gel 1% apply to right elbow topically four tumes a day for pain management, apply two grams; and - to administer diclofenac sodium external gel 1% apply to left knee topically four tumes a day for pain (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management, apply four grams; LVN 5 verified the pharmacy label on the diclofenac medication did not match the physician's orders for Resident 4. On 2/23/26 at 1330 hours, the DON and the Administrator were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Labeling of Medication revised date 4/2025 showed, any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. Labels for individual resident medications include all necessary information, such as the name, strength, quantity of the drug, and directions for use. On 2/18/26 at 0853 hours, during the medication pass observation, Resident 59's baclofen bubble pack instructions showed baclofen 10 mg give one tablet by mouth three times a day for muscle spasm. Medical record review for Resident 59 was initiated on 2/18/26. Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's Order Summary Report showed a physician's order dated 2/15/26, to administer baclofen tablet 10 mg give 0.5 tablet (5 mg) by mouth three times a day for muscle spasm. Review of Resident 59's H&P examination dated 2/17/26, showed Resident 59 had the capacity to understand and make decisions. On 2/18/26 at 1526 hours, an interview was conducted with LVN 1. LVN 1 verified the physician's orders for the baclofen 10 mg was to give 0.5 tablet, but the baclofen bubble pack showed baclofen 10 mg to give one tablet by mouth three times a day. LVN 1 verified the orders did not match and there was an error on Resident 59's baclofen bubble pack medication label. In addition, LVN 1 stated the physician's order in the MAR should match the resident's bubble pack medication label for safety and to prevent medication error. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices were implemented as evidenced by: * The facility failed to ensure a visitor for Resident 61 who was on C-Diff isolation was educated on isolation precautions like handwashing instead of using ABHR and wearing gloves. * The facility failed to ensure the housekeeper wore a protective gown when sorting soiled linens. * The facility failed to ensure the employee's personal belongings were not stored with the clean blankets and tablecloths used by the residents in the clean linen area. * The facility failed to ensure Resident 43's urinal filled with urine was not placed near the resident's cupcake. These failures had the potential for spreading infection.Findings: Review of the facility's P&P titled Section: Infection Control, Subject: Standard and Transmission Based Precautions dated 6/2024 under the Policy Implementation section, showed the following: a. Standard Precautions are observed by all employees to prevent direct body contact with blood or other potentially infectious materials. Proper selection and utilization of PPE (personal protective equipment), such as gown and gloves, along with hand hygiene, safe injection practices, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing of reusable medical equipment are components of standard precautions procedures and practices. Gloves should be worn whenever exposure to the following is panned or anticipated: blood/blood products, body fluids with visible blood, urine, feces, saliva, mucous membranes, wound drainage, drainage tubes, non-intact skin, body fluids or performing venipuncture or invasive procedure. Gowns should be worn when there is potential for soiling clothing with blood or body fluids. Hand hygiene- handwashing with soap and water is performed after contact with mucous membranes/blood/body fluids, soiled linens/equipment, and potentially contaminated surfaces/substances; and b. Contact Precautions, in addition to standard precautions, use contact precautions in the care of residents known or suspected to have serious illness easily transmitted by direct contact or by indirect contact with items in the resident's environment. Illnesses requiring contact precautions may include, but are not limited to: presence of stool incontinence (may include residents with norovirus, rotavirus, or clostridium difficile), draining wounds, uncontrolled secretions, pressure ulcers that are not contained or covered, presence of generalized rash, or presence of ostomy tubes and/or bags draining body fluids. Gloves should be worn before entering the room and while providing care for a resident. Gloves should be changed after having contact with infective material. Remove gloves before leaving resident's room and perform hand hygiene immediately. A gown should be worn before entering the room. Properly remove and discard gown before exiting the resident's room to contain pathogens. Review of the facility's P&P titled Contact Isolation Precautions Policy revised 7/2025 under the Indications for Contact Precautions section showed MDROs such as MRSA, VRE, and CRE, clostridium difficile (C. difficile), uncontrolled draining wounds, scabies or lice infestation, gastrointestinal infections with fecal incontinence, and other infections as determined by the IP or physician. The Personal Protective Equipment (PPE) section showed to perform hand hygiene before entering the room, don gown and gloves upon entry to the room, remove gown and gloves before exiting the room, and perform hand hygiene immediately after removing PPE. Review of the facility's P&P titled Clostridium Difficile revised 6/2025 under the Policy and Interpretation section showed C. difficile is transmitted via fecal-oral route. Therefore, any resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care-activity that involves contact with the resident's mouth when hands or instruments are contaminated may provide an opportunity for transmission. The Steps Toward Prevention and Early Intervention section showed frequent handwashing with soap and water by staff and residents, wearing gloves when handling feces or articles contaminated with feces or articles contaminated with feces, and disinfection of items with potential fecal soiling. Review of the facility's P&P titled Visitation, Infection Control During revised 8/2019 under the Policy and Interpretation section showed the following: - Upon admission of the resident to the facility, family members are provided with education that may include an explanation of the facility's infection control practices during visitation. This may include information pertaining to the following: standard precautions; hand hygiene; respiratory hygiene; vaccinations; and signs and symptoms of common communicable diseases; -Visitors are encouraged to perform hand hygiene upon arrival, before entering a resident's room and when leaving the facility; and - Visiting a resident who is under transmission-based precautions is permitted. Family members and visitors who are providing care or have very close contact with the resident are trained regarding the appropriate use of infection control barriers such as personal protective equipment. Adherence to transmission-based precautions by visitors is required. Review of the facility's P&P titled Employee Personal Belongings Storage Policy and Procedure revised 4/2025 showed the facility ensures employee's personal belongings are stored safely to prevent contamination and maintain infection control compliance. Personal items must be stored in lockers or staff-only designated areas away from care and food service zones. 1. On 2/17/26 at 0805 hours, during the initial tour of the facility, a contact precautions signage was observed outside the room of Resident 61. Resident 61 was observed sleeping in bed. The contact precautions signage showed: - Clean their hands before entering the room and when leaving the room with an image of hands using sanitizer before the word clean and an image of hands washing under the faucet after the words leaving the room; - Put on gloves before room entry, discard gloves before room exit; - Put on gown before room entry, discard gown before room exit; and - Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Medical record review for Resident 61 was initiated on 2/17/26. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 61's Order Summary Report showed the following physician's orders: - dated 2/12/26, for contact isolation due to C. diff positive status until 2/17/26 at 2359 hours; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 2/12/26, to discontinue isolation when the resident had three formed stools. Review of Resident 61's H&P examination dated 2/13/26, showed Resident 61 did not have the capacity to understand and make decisions. Review of Resident 61's Bowel Elimination Record showed on 2/16/26 for the evening shift (1500 to 2300 hours) and night shift (2300 to 0700 hours), Resident 61 had medium loose/diarrhea stools. On 2/17/26 at 0945 hours, an observation for Resident 61 and concurrent interview was conducted with Resident 61's Responsible Party. Resident 61 was observed sleeping in bed. Resident 61's Responsible Party was observed seating in the chair inside Resident 61's room wearing a gown but no gloves. Resident 61's Responsible Party was observed touching the bed of Resident 61 and placed notebook and cellphone on top of the bed where Resident 61 was lying. Resident 61's Responsible Party stated Resident 61 was isolated for C. diff when asked why the resident on isolation. Resident 61's Responsible Party stated she came daily to visit Resident 61 and stayed almost five hours. Resident 61's Responsible Party stated Resident 61 was still having diarrhea. Resident 61's Responsible Party stated she was not told to wear gloves if she was inside the room when asked if she knew she had to wear gloves. Resident 61's Responsible Party stated she used the hand sanitizer installed in the room's wall for cleaning her hands when she left the room when asked what she used for cleaning her hands whenever she left the room. Resident 61's Responsible Party further stated no one told her to wear the gloves when she was inside Resident 61's room, she could not place her personal items on the bed of the resident, and she had to wash her hands whenever she left the room when SA educated her about the precautionary measures related to C. diff. On 2/17/26 at 1010 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated Resident 61 was on contact isolation for C. diff. LVN 1 stated Resident 61 was still having diarrhea. LVN 1 stated for contact isolation, everyone who entered the room should wear gown and gloves, and hand washing is the required way of cleaning the hands when leaving the room of the resident. LVN 1 stated she knew Resident 61's Responsible Party was inside the resident's room. LVN 1 further stated Resident 61's Responsible Party visited the resident almost every day. LVN 1 was informed of the above findings and stated she would always remind Resident 61's Responsible Party to wear the gown and gloves. On 2/19/26 at 1616 hours, an interview was conducted with the IP. The IP stated visitors were notified immediately when the resident had an infection and requiring certain isolation precautions. The IP stated she would call the resident's designee/s and explain what precautions needed to be done when they would visit the resident. The IP stated they would also have signage posted outside the room visible to the employees and visitors regarding what type of isolation which include what PPE to be used and how to do the hand hygiene. The IP further stated she would do a follow up visit when she knew the resident's designee was in the facility and she would provide reeducation regarding the isolation precautions needed. The IP was informed and acknowledged the above findings for Resident 61. The IP stated whenever she saw Resident 61's RP in the resident's room, she would remind her to wear the gown. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 61. The DON stated on the day of 2/17/26, when she saw Resident 61's Responsible Party in the room, she was the one who handed Resident 61's Responsible Party the gown to wear and reminded her to wear gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 2/18/26 at 1501 hours, a laundry services observation was conducted with the Maintenance Director. The Housekeeper was observed sorting the soiled linens and trash linens in the soiled linen gate area wearing gloves and not wearing a protective gown. The Maintenance Director stated the Housekeeper should have worn also a protective gown to protect himself and prevent the spread of infection since the Housekeeper would also go to the residents' room to clean. 3. On 2/18/26 at 1526 hours, during the laundry services observation, the clean white rack in the laundry room's clean area which had the clean blankets and tablecloths used for the residents was observed with the following employee's personal belongings: - gray hair brush with hair; - two black combs with hair; - small bottle of cologne; - three lip balms; - nail clipper; - nail file; - small red tube of lotion; - four ampules of refresh plus lubricant eye drops; - chocolates- two kisses and two small bars (hershey and kitkat); - candies; - coins; - one white round container which was labeled with an employee's name per Maintenance Director; - one packet of muscle jel pain reliever; - one packet of 1000 mg vitamin C; - one opened packet of iodized salt; and - pens, markers, notebooks, post-it notes. The Maintenance Director acknowledged the above findings and stated there should never be any employee personal items stored in the area they used to store linens for the residents. The Maintenance Director further stated he would have the blankets and tablecloths washed again. On 2/19/26 at 1720 hours, an interview was conducted with the IP. The IP stated the staff should wear protective gowns and gloves when sorting out soiled linens and trash which were taken out from the residents' room to prevent the spread of infection and to protect the staff themselves. The IP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated there should be no employee's personal belongings stored in the laundry area whether in the dirty or clean area to prevent cross contamination. The IP further stated the employees were given designated places or lockers in the facility to keep their personal belongings. The IP was informed and acknowledged the findings during the laundry services observation. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 2/19/26 at 0919 hours, an observation and concurrent interview was conducted with the Maintenance Director. Resident 43 was observed lying in bed with the bedside table had urinal filled with urine and was placed near the resident's cupcake. The Maintenance Director acknowledged the above findings and stated the urinal filled with urine should not be on top of the bedside table next to the food due to infection control and it's not good for the resident. Medical record review for Resident 43 was initiated on 2/18/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P dated 1/26/26 showed Resident 43 had the capacity to understand and make decisions. On 2/19/26 at 1632 hours, RN 1 was informed of and acknowledged the above findings. RN 1 stated the urinal filled with urine should not be placed next to the resident's food due to infection control issue. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review and facility P&P review, the facility failed to ensure the residents' bed inspection and entrapment assessments were conducted and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for three of four final sampled residents (Residents 4, 21, and 43) and one non-sampled resident (Resident 61) reviewed for the use of side rails. * The facility failed to ensure a bed inspection was completed for Resident 21 who was on bariatric bed. * The facility failed to ensure an entrapment assessment was accurately conducted for Resident 4 who had bilateral 1/2 side rails. * The facility failed to ensure an entrapment assessment was accurately conducted for Resident 43 who had bilateral 1/2 side rails. * The facility failed to ensure a bed inspection was completed for Resident 61 who was on bariatric bed. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: 1. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Inspection and Maintenance Policy revised 4/2025 showed the following: - All beds shall be inspected routinely; - Applies to all resident beds, rails, mattresses, wheels, and controls; - The nursing department is responsible for visual safety checks each shift, and the maintenance (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	department is responsible for monthly and quarterly inspections; and - The inspection areas included structural integrity, electrical and mechanical function, wheel locks, mattress condition, and entrapment risks. On 2/17/26 at 0908 hours, during the initial tour of the facility, Resident 21 was observed lying in bed sleeping, with bilateral side rails elevated. On 2/18/26 at 1100 hours, an observation and interview was conducted with Resident 21. Resident 21 was observed awake in bed, with bilateral side rails elevated. Resident 21 stated he used the bilateral side rails when he turned and repositioned. On 2/19/26 at 1005 hours, an observation of Resident 21 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 21 was in bed with bilateral side rails elevated. CNA 1 stated Resident 21 used the side rails to turn from side to side. Medical record review for Resident 21 was initiated on 2/17/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's Order Summary Report showed a physician's order dated 7/17/25, for an adjustable bed with bilateral 1/2 side rails up for bed mobility and repositioning. Review of Resident 21's plan of care showed a care plan problem dated 7/17/25, to address the risk for injury/ entrapment related to the use of bilateral 1/2 side rails. The interventions/ tasks included to evaluate the bed system safety zone for entrapment risk Review of Resident 21's Safety Assessment for Side Rail Usage v2 dated 7/17/25, under Bedframe/Mattress/Rail section, did not show the bedframe length, mattress type, mattress height and length. 2. On 2/17/26 at 1013 hours, 2/18/26 at 0805 hours, and 2/19/26 at 0804 hours, Resident 4 was observed lying in bed sleeping, with bilateral side rails elevated. On 2/19/26 at 1046 hours, an interview for Resident 4 was conducted with CNA 2. CNA 2 stated Resident 4 did not used the side rails to turn, but when the resident was being turned, she observed Resident 4 pushing the side rails. Medical record review for Resident 4 was initiated on 2/17/26. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 3/20/25, for an adjustable bed with padded bilateral 1/2 side rails up for bed mobility and repositioning. Review of Resident 4's plan of care showed a care plan problem dated 3/20/25, to address the use of bedside padded rails up while in bed as enabler for ease in turning and repositioning, for promotion of independence and assist with bed mobility. The goal was for the resident's extremities to be free from any form or injury due to accidental entrapment. Review of Resident 4's Safety Assessment for Side Rail Usage v2 dated 5/2/25, under Bed System (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safety Zones section, showed the bed system zones evaluated for entrapment risk for 1/4 side rails on both sides, and zones 1 to 7 were checked off. On 2/19/26 at 1120 hours, an interview and concurrent facility document review for Residents 4 and 21 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including the entrapment assessment of all the beds in the facility. Review of the facility's document titled Resident Beds: Monthly/Yearly Preventive Maintenance dated 11/18/25, 12/18/25, 12/19/25, 1/16/26 and 1/17/26, showed the following: - A note on top of the document showed to check the following items throughout the facility and make adjustments or repairs as needed: wheels, brakes, rails, nuts and bolts, bed controls and power cord; - The dates recorded were 11/18/25, 12/18/25, 12/19/25, 1/16/26 and 1/17/26. - No documentation of the bedframe length, mattress type, mattress height and length; and - No documentation of the measurement of the applicable entrapment zones. The Maintenance Director verified the above findings. The Maintenance Director stated he used a tape measuring device to measure the entrapment zones on each of the bed with side rails. The Maintenance Director stated he would measure the applicable entrapment zones only when he installs the side rails. The Maintenance Director stated he did not have to document the measurements of the bedframe length, mattress type, mattress height and length, and applicable entrapment zones because the facility's beds were all regular beds using regular mattresses. The Maintenance Director verified Resident 21 had a bariatric bed and not a regular bed. On 2/19/26 at 1214 hours, an interview and concurrent medical record review for Residents 4 and 21 was conducted with RN 1 and LVN 4. RN 1 and LVN 4 verified the above findings. LVN 4 stated the residents were evaluated by the therapist, and the therapist would give their recommendation on side rail use to the nursing department. LVN 4 stated the nursing department would inform the physician, obtain a physician's order for side rails, and inform the maintenance department to install the side rails. LVN 4 stated the maintenance department measured the entrapment zones and the bedframe length, mattress type, mattress height and length, and informed the nurses if the bed passed the entrapment assessment. LVN 4 stated the nurses would document the bed assessment and entrapment assessment in the side rails assessment in the resident's electronic health record. LVN 4 verified Resident 21's bed inspection of the bedframe length, mattress type, mattress type, mattress height and length was not documented in the resident's electronic health record. RN 1 verified Resident 4's entrapment assessment was incorrect as the side rail assessment showed 1/4 side rails instead of 1/2 side rails per the physician's assessment, and zone 5 was checked. RN 1 stated zone 5 was for split side rails which Resident 4 did not have. On 2/23/26 at 1330 hours, the DON and the Administrator were informed and acknowledged the above findings. 3. On 2/17/26 at 0941 hours, during the initial tour, Resident 43 was observed lying in bed, awake, oriented to name and verbally responsive. Resident 43's bed had bilateral half side rails elevated at the head of the bed. (continued on next page)

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

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 43 was initiated on 2/18/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 1/26/26, showed Resident 43 had the capacity to understand and make decisions. Review of Resident 43's Order Summary Report for 2/2026 failed to show a physician's order for the use of bilateral half side rails. Further review of Resident 43's medical record failed to show documented evidence of entrapment assessment was completed for the use of bilateral half side rails. On 2/18/26 at 1610 hours, an observation, interview, and concurrent medical record review for Resident 43 was conducted with LVN 3. LVN 3 acknowledged the findings. LVN 3 was asked about the process prior to applying side rails and stated there should be a side rail recommendation from rehab, a physician's order, side rail assessment, informed consent, and care plan to verify the need of side rails and to prevent entrapment. On 2/19/26 at 1120 hours, an interview and concurrent facility record review for Resident 43 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including the entrapment assessment of all the beds in the facility. Review of the facility's document titled Resident Beds: Monthly/Yearly Preventive Maintenance dated 1/16/26 and 1/17/26 failed to show documented evidence of entrapment assessment was completed for the use of bilateral half side rails for Resident 43. The Maintenance Director verified the above findings. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings. Cross reference to F700. 4. On 2/17/26 at 0805 hours, during the initial tour of the facility, Resident 61 was observed sleeping in a bariatric bed on a LAL mattress. The LAL mattress was observed set in a static mode, the lock out mode was turned on, and there was no green light for the soft to firm bars. Medical record review for Resident 61 was initiated on 2/17/26. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 61's H&P examination dated 2/13/26, showed Resident 61 did not have the capacity to understand and make decisions. Review of Resident 61's Order Summary Report showed a physician's order dated 2/11/26, for bariatric bed with bilateral 1/2 siderails for bed mobility and repositioning and low air loss mattress for skin management every shift. On 2/17/26 at 1010 hours, an interview and concurrent medical record review for Resident 61 was conducted with LVN 1. LVN 1 verified Resident 61 had a bariatric bed with LAL mattress. LVN 1 verified Resident 61's bed inspection of the bed frame length, mattress type, mattress type, mattress height and length were not documented in the resident's electronic health record. LVN 1 further stated it was the Maintenance Department who did the monthly bed inspection. (continued on next page)

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	555671	A. Building B. Wing	02/23/2026

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/19/26 at 1120 hours, an interview and concurrent facility record review for Resident 61 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including the entrapment assessment of all the beds in the facility. Review of the facility's document titled Resident Beds: Monthly/Yearly Preventive Maintenance showed the following: - A note on top of the document showed to check the following items throughout the facility and adjust or repair as needed: wheels, brakes, rails, nuts and bolts, bed controls and power cord; - The dates recorded were 11/18/25, 12/18/25, 12/19/25, 1/16/26 and 1/17/26; and - No documentation of the bed frame length, mattress type, mattress height and length. The Maintenance Director verified the above findings. The Maintenance Director stated he did not have to document the measurements of the bed frame length, mattress type, mattress height and length, and applicable entrapment zones because the facility's beds were all regular beds using regular mattresses. The Maintenance Director verified Resident 61 had a bariatric bed and not a regular bed. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 61.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled resident (Resident 43) reviewed for the side rail use remained free from the accident hazards associated with the use of the elevated side rails. * The facility failed to obtain informed consent for the use of the bilateral upper side rails for Resident 43. This failure had the potential for the resident to be unaware of the risks associated with the use of the bilateral upper side rails and risk for serious injury to the resident.Findings: Review of the facility's P&P titled Bed Safety and Bed Rails date revised 8/2025 showed the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the content:a. The assessed medical needs that will be addressed with the use of bed rails;b. The resident's risks from the use of bed rails and how these will be mitigated;c. The alternatives that were attempted but failed to meet the resident's needs; andd. The alternatives that were considered but not attempted and the reasons. On 2/17/26 at 0941 hours, during the initial tour, Resident 43 was observed lying in bed, awake, oriented to name and verbally responsive. Resident 43's bed had bilateral half side rails elevated at the head of the bed. Medical record review for Resident 43 was initiated on 2/18/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 1/26/26, showed Resident 43 had the capacity to understand and make decisions. Review of Resident 43's medical record failed to show informed consent was obtained for the use of bilateral upper side rails. On 2/18/26 at 1610 hours, an observation, interview, and concurrent medical record review for Resident 43 was conducted with LVN 3. LVN 3 verified Resident 43's medical record failed to show informed consent was obtained for the use of side rails. LVN 3 stated there must be a side rail recommendation from rehab, a physician's order, side rail assessment, informed consent, and care plan to verify the need of side rails and to prevent entrapment. On 2/23/26 at 1537 hours, during an interview with the DON, the DON was informed and verified the above findings.

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	555671	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine whether it was safe for one of 12 final sampled residents (Resident 21) to self-administer the medications left at bedside. * Resident 21 was observed with multiple medications at bedside. However, Resident 21 was assessed to be mentally and physically incapable of self-administering medications. In addition, there were no physician's orders to self-administer and to administer the medications found at bedside. These failures had the potential for Resident 21 to administer the medications inaccurately and could affect his well-being.Findings: Review of the facility's P&P titled Self-Administration of Medications revised 2/2025 showed the following:- Residents have the right to self-administer medication if the IDT has determined that is clinically appropriate and safe for the resident to do so;- As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident;-If it is deemed safe and appropriate for the resident to self-administer medications, this is documented in the medical record and the care plan;-Self-administered medications are stored in a safe and secure place, which are not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them; and-Any medication found at the bedside that is not authorized for self-administration is turned over to the nurse in charge for return to the family or responsible party. On 2/17/26 at 0908 hours, Resident 21 was observed sleeping in bed. A bag containing an albuterol puff was observed on top of a black container on the resident's overbed table. On 2/18/26 at 1100 hours, an observation and concurrent interview was conducted with Resident 21. Resident 21 was observed lying in bed in the room. A bottle of Refresh eyedrops (artificial tears), a bottle of ketorolac eyedrop (ophthalmic anti-inflammatory medication) and a bottle of vitamins (supplement) were observed inside a black box on his overbed table. Resident 21 stated he administers the eyedrops and takes the vitamin as needed. Resident 21 stated the nurses were aware he was administering the medications himself. On 2/18/26 at 1441 hours, an observation for Resident 21 and interview was conducted with LVN 3. LVN 3 stated Resident 21 ordered his medications online, and he had confiscated medications from Resident 21 before. LVN 3 was observed taking out a black box container from Resident 21's room. On 2/18/26 at 1451 hours, an observation, interview and concurrent medical record review for Resident 21 was conducted with LVN 3 and the DON. The following was observed inside Resident 21's black box container:- Two canisters of zinc oxide (topical protectant);- A bottler of guaifenesin mucus relief (expectorant);- A bottle multivitamin with mineral and antioxidant (supplement);- A bottle of diphenhydramine (antihistamine);- A bottle of Xylimelts (over-the-counter saliva stimulant);- A tube of ketoconazole cream (topical antifungal);- Four tubes of cortisone cream (corticosteroid);- Two tubes of Mupirocin cream (topical antibiotic);- A bottle of Refresh eyedrops;- A bottle of ketorolac eyedrops; and- A bottle of glucose tablets (over-the-counter antihyperglycemic agents). Medical record review for Resident 21 was initiated on 2/17/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's Medication Self-Administration Screen v1 dated 5/2/25, showed Resident 21 was not mentally able to self-administer medications and not a candidate for self-administering his own medication. Review of Resident 21's H&P examination titled 5/5/25, showed Resident 21 had the capacity to understand and make decisions. Review of Resident 21's medical record failed to show a physician's order for the administration of the medications found at bedside nor to self-administer those medications. Additionally, there was no care plan developed to address Resident 21's self-administration of the medications. LVN 3 and the DON verified the above findings.

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	555671	A. Building B. Wing	02/23/2026

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Terrace View Care Center	201 East Bastanchury Fullerton, CA 92835

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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 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.

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	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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled resident (Resident 7) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to implement Resident 7's non-pharmacological interventions for the use of mirtazapine and trazodone (antidepressant) medications. This failure had the potential for adverse effects from the psychotropic medications and to negatively impact the residents' well-being.Findings: Review of the facility's P&P titled Psychoactive/ Behavior Assessment (undated) showed prior to the use of Psychoactive medication there should be a documented trial of alternatives (non-pharmacological intervention/ NPI). In addition, further review of the facility's P&P titled Psychotropic Medication Use dated 7/2025 showed, non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Medical record review for Resident 7 was initiated on 2/17/26. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 7's Order Summary Report showed an order dated 1/12/26, to administer mirtazapine 15 mg give one tablet by mouth at bedtime and trazodone 50 mg give one tablet by mouth at bedtime for major depressive disorder. Review of Resident 7's care plan for the use of mirtazapine and trazodone medications dated 1/12/26, showed interventions including providing non-pharmacological interventions such as approached resident calmly, unhurriedly, refocus, redirection, provide assistance and encouragement to Resident 7. Review of Resident 7's H&P examination dated 1/13/26, showed Resident 7 had fluctuating capacity to understand and make decisions therefore, care was discussed with the spouse. Review of Resident 7's MAR for January and February 2026 failed to show documented evidence non-pharmacological interventions were attempted prior to the administration of Resident 7's mirtazapine and trazodone medications. Further review of Resident 7's medical record failed to show documented evidence of non-pharmacological interventions were attempted prior to the administration of Resident 7's mirtazapine and trazodone medications. On 2/23/26 at 1008 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 acknowledged the above findings for Resident 7 and stated non-pharmacological interventions should have been provided to the resident to evaluate the need and limit the use of the antidepressant medications. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings. Cross reference to F756.

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	555671	A. Building B. Wing	02/23/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR was complete for one of 12 final sampled residents (Resident 5). * Resident 5 did not receive a Level II mental health evaluation, after a Level 1 Screening was positive for serious mental illness reviewed for PASRR. This failure posed the risk for Resident 5 not receiving specialized services beneficial to the resident's wellbeing.Findings: Medical record review for Resident 5 was initiated on 2/17/26. Resident 5 readmitted to the facility on [DATE]. Review of Resident 5's Level 1 PASRR screening completed by the SNF dated 12/29/25, showed Resident 5 was positive for serious mental illness and a Level II mental health evaluation referral was required. Review of Resident 5's Unable to Complete Level II Evaluation for Serious Mental Illness dated 1/1/26, showed a Level II Mental Health Evaluation was not scheduled for the following reason: facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening. The case was now closed. To reopen, the facility must resubmit a new Level I Screening. Facilities discharging to a SNF must submit another screening as a preadmission screening (PAS). SNFs must submit another screening as a Resident Review (RR). On 2/23/26 at 0930 hours, an interview and concurrent medical record review for Resident 5 was conducted with the MDS Coordinator. The MDS Coordinator stated she was responsible for following up the PASRR. The MDS Coordinator stated the MRD received the documents from the California Department of Health Care Services and if there was a needed follow up regarding the PASRR, the MRD would alert or notify her. The MDS Coordinator verified the Level II Mental Health Evaluation for Resident 5 was not completed. The MDS Coordinator stated she was not aware of Resident 5's Unable to Complete Level II Evaluation for Serious Mental Illness dated 1/1/26 sent to the facility. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.

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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to develop the comprehensive plan of care to reflect the individual care needs for two of 12 final sampled residents (Residents 21 and 57). * The facility failed to develop a care plan problem to address Resident 21's behavior of ordering and keeping medications at bedside. * The facility failed to develop a care plan problem to address Resident 57's Permacath related to dialysis use. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents.Findings: 1. On 2/17/26 at 0908 hours, Resident 21 was observed sleeping in bed. A bag containing an albuterol (used to treat sudden breathing issues by relaxing muscles in the airways) inhaler was observed on top of a black container on the resident's overbed table. On 2/18/26 at 1100 hours, Resident 21 was observed lying in bed in the room. A bottle of Refresh eyedrops (artificial tears), a bottle of ketorolac eyedrop (ophthalmic anti-inflammatory medication) and a bottle of vitamins (supplement) were observed inside a black box on his overbed table. Resident 21 stated he administered the eyedrops and took the vitamin as needed. Resident 21 stated the licensed nurses were aware he was administering the medications himself. On 2/18/26 at 1441 hours, an observation for Resident 21 and concurrent interview was conducted with LVN 3. LVN 3 stated Resident 21 ordered his medications online, and he had confiscated the medications from Resident 21 before. LVN 3 was observed taking out a black box container from Resident 21's room. Medical record review for Resident 21 was initiated on 2/17/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's plan of care failed to show a care plan problem was developed to address Resident 21's self-administration of the medications. Further review of Resident 21's plan of care failed to show a care plan problem to address Resident 21's behavior of ordering and keeping medications at bedside. On 2/18/26 at 1451 hours, an observation for Resident 21 was conducted with LVN 3 and the DON. Several medications were observed inside Resident 21's black box container. LVN 3 and the DON verified the above findings. The DON stated Resident 21 had been ordering medications online, and he kept these medications at bedside. The DON verified a care plan problem was not developed to address Resident 21's non-compliance of not keeping medications at bedside. 2. Medical record review for Resident 57 was initiated on 2/17/26. Resident 57 was admitted to the facility on [DATE]. Review of Resident 57's Order Summary Report showed the following physician's orders:- dated 2/11/26, for enhanced barrier precaution due to the presence of a Permacath; and- dated 2/18/26, to have dialysis every Tuesday, Thursday and Saturday. Review of Resident 57's plan of care did not show a care plan was developed to address Resident 57's Permacath related to dialysis. On 2/19/26 at 1537 hours, an interview and concurrent medical record review for Resident 57 was conducted with LVN 4. LVN 4 verified Resident 57 had a Permacath for dialysis use. LVN 4 was not able to show a care plan was developed to address Resident 57's Permacath. LVN 4 stated there should be a care plan to address the care and what to do during an emergency related to Resident 57's Permacath. On 2/23/26 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	555671	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one non-sampled resident (Resident 61) reviewed for pressure injury was provided the necessary care and services. The facility failed to ensure Resident 61's LAL mattress setting was accurate to the resident's weight and comfort. This failure had the potential for the resident not to receive the appropriate care and services to promote skin healing. Findings: According to National Pressure Injury Advisory Panel (NPIAP) 2019 Clinical Practice Guideline, a support surface is a specialized device designed for pressure redistribution, microclimate management, and other therapeutic functions. These devices include mattresses, bed systems, overlays, and seat cushions. In low air loss mattresses, alternating air pressure mode provides pressure relief and redistribution by cyclically inflating and deflating air cells, promoting circulation and preventing pressure ulcers. Static mode, on the other hand, keeps the cells inflated at a constant pressure, offering a stable surface for patient care activities and transfers. Review of the facility's P&P titled Low Air Loss Mattress Policy and Procedure revised 4/2025 showed the low air loss mattresses will be used for residents at risk or with existing pressure injuries per provider order. The administration ensures availability, nursing monitors use, and Maintenance inspects equipment. The daily monitoring includes checking inflation, power, alarms, skin integrity each shift. Review of the Power Pro Elite Model 9500's Operational Manual (undated) showed the device is an alternating pressure mattress system with several therapy modes, designed for pressure injury management. The Main Mode Settings section showed the following:- Alternating Mode: Designed for active pressure relief. The system alternates the pressure in the air cells;- Static Mode: Used for safer transfer and patient care. The mattress maintains a consistent pressure (approximately 70% of the selected alternative pressure) without alternating;- Bariatric Mode: recommended for patients over 350 pounds to provide additional support; and- Lock-out Mode: The control panel automatically locks after two minutes of inactivity to prevent accidental changes. On 2/17/26 at 0805 hours, during the initial tour of the facility, Resident 61 was observed sleeping on a bariatric bed with a LAL mattress. The LAL mattress was observed set on static mode, the lock out mode was turned on, and there was no green light for the soft to firm bars. Medical record review for Resident 61 was initiated on 2/17/26. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 61's H&P examination dated 2/13/26, showed Resident 61 had no capacity to understand and make decisions. Review of Resident 61's MDS assessment dated [DATE], showed Resident 61 was dependent with mobility. Review of Resident 61's Weights and Vital Signs Summary (undated) showed the last weight recorded was 231 pounds via mechanical lift on 12/18/25 at 1346 hours. Review of Resident 61's Order Summary Report showed a physician's order dated 2/11/26, for bariatric bed with bilateral 1/2 siderails for bed mobility and repositioning and low air loss mattress for skin management every shift. Review of Resident 61's Progress Note dated 2/16/26 at 1210 hours, showed Resident 61 refused to be weighed and the risk and benefits were explained. On 2/17/26 at 0945 hours, an observation for Resident 61 and concurrent interview was conducted with Responsible Party 2. Resident 61 was observed sleeping on a bariatric bed with a LAL mattress. The LAL mattress was observed set on a static mode, the lock out mode was turned on, and there was no green light for the soft to firm bars. Responsible Party 2 stated Resident 61 had bed sores in the buttocks before, but the bed sores were healed. Responsible Party 2 stated she was informed by the licensed nurses the type of bed and mattress used to prevent pressure injury. Responsible Party 2 stated the licensed nurses fixed the bed and she did not know how to operate it. Responsible Party 2 further stated Resident 61 could not say or request anything about the setting of the bed. On 2/17/26 at 1010 hours, an observation and concurrent interview was conducted for Resident 61 with LVN 1. LVN 1 stated Resident 61 required total care for the activities of daily living and dependent with mobility. LVN 1 stated Resident 61 had high risk for skin breakdown. LVN 1 (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified Resident 61's LAL mattress was set on static mode. LVN 1 stated it should be set to alternating mode for proper distribution of air and as preventative measure. LVN 1 stated the static mode setting was used when the resident was being turned or cleaned. LVN 1 further stated the treatment nurse monitored the use of LAL mattress for the residents. LVN 1 was observed changing the LAL mattress' setting to alternate mode. On 2/17/26 at 1016 hours, an interview was conducted for Resident 61 with LVN 2. LVN 2 stated Resident 61 had redness on the buttock, and she was providing treatment to the area. LVN 2 stated the resident had high risk for developing skin breakdown. LVN 2 stated the facility provided the LAL mattress to the residents with Stage 3 to 4 pressure injury, DTI s and for the residents who were immobile as a preventative measure. LVN 2 stated the LAL mattress's setting was being monitored by the licensed nurses. LVN 2 stated the CNAs could not change the setting, but the CNAs could report to the licensed nurses if the bed was alarming or not working properly. LVN 2 stated the LAL mattress should be set in alternate mode and the firmness of the mattress should coincide with the resident's weight or comfort. LVN 2 further stated the static mode was used when the facility staff were provided resident care activities like cleaning, repositioning or transferring the resident from bed to chair. LVN 2 was informed and acknowledged the findings for Resident 61. On 2/23/26 at 1431 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 61.

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	555671	A. Building B. Wing	02/23/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 12 final sampled residents (Resident 7) was free from accident hazards. * The facility failed to implement bilateral floor mattress as ordered by the physician as a fall risk precaution for Resident 7. This failure had the potential for serious injury to the resident.Findings: Review of the facility's P&P titled Floor Mat Safety and Use revised date 10/2025 showed the purpose is to prevent slips, trips, and falls related to improper placement, condition, or maintenance of floor mats and to ensure compliance with safety standards. All floor mats must be non-slip, lay flat, remain clean and dry, and not create hazards or obstruct mobility devices. On 2/17/26 at 0930 hours, during the initial tour of the facility, Resident 7 was observed lying in bed with bilateral floor mats in place. On 2/19/26 at 0939 hours, an observation of Resident 7 and concurrent interview was conducted with CNA 3. Resident 7 was lying in bed with only one floor mat on the left side of the bed in place. CNA 3 stated she recalled Resident 7 had bilateral floor mats used for safety. On 2/19/26 at 1053 hours, an interview was conducted with CNA 4. CNA 4 stated she recalled Resident 7 had attempted to get out of bed and floor mats were used for safety. Medical record review for Resident 7 was initiated on 2/17/26. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 7's care plan for high risk falls related to Alzheimer's and dementia dated 1/11/26, showed interventions including the adjustable bed in low position and application of bilateral floor mattress at bedside for safety. Review of Resident 7's Order Summary Report showed a physician's order dated 1/12/26, for adjustable bed in low position with bilateral floormats due to poor safety awareness, monitor placement every shift. Review of Resident 7's H&P examination dated 1/13/26, showed Resident 7 had fluctuating capacity to understand and make decisions therefore, care was discussed with the spouse. Review of Resident 7's admission MDS assessment dated [DATE], showed Resident 7 had severe cognitive impairment. The MDS further showed Resident 7 had impairment to one lower extremity. On 2/19/26 at 1555 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 7 had a fall incident in the past and bilateral floor mats should be in place at all times when resident was in bed. RN 1 further stated the physician's order should be followed. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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	555671	A. Building B. Wing	02/23/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 12 final sampled residents (Resident 9) received care and services to maintain acceptable nutritional status. * The facility failed to ensure the RD's recommendations for Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily was implemented. This failure had the potential to compromise Resident 9's nutritional status.Findings: Review of the facility's P&P titled Weight Loss - Clinical Protocol revised date 9/2025 showed the physician will help identify medical conditions (cancer, cardiac or renal disease, depression, dental problems, etc.) and medications that may be causing weight gain or loss or increasing risk for either gaining or losing weight. The physician (or staff, based on a discussion with the physician) will document relevant medical information regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations such as where multiple causes coexist. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). When medical conditions or medication- related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/ patient's responses, goals, wishes, prognosis, and complications. Medical record review for Resident 9 was initiated on 2/18/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 1/22/26, showed Resident 9 had no capacity to understand and make decisions. In addition, Resident 9 had a diagnosis of ESRD and was on renal dialysis. Review of Resident 9's Nutritional Assessment conducted by the RD dated 1/21/26, showed Resident 9's IBW BMI 23.1 (low for resident's age) and Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily was recommended to be started. Review of Resident 9's Order Summary Report for January 2026 failed to show a physician's order to administer Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily. Review of Resident 9's MAR for January 2026 failed to show a physician's order to administer Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily. Review of Resident 9's Licensed Progress Notes for January 2026 failed to show documentation the physician was notified of the RD's recommendations to start Resident 9 on Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily. On 2/23/26 at 1436 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 1. RN 1 verified there was no physician's order to administer Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily. RN 1 verified there was no documentation to show the physician was notified of the RD's recommendations to start Cholecalciferol 2,000 IU oral daily, Vitamin C 500 mg oral daily for 30 days and Prostat SF (liquid protein supplement) 30 ml oral daily. In addition, RN 1 stated licensed nurses were responsible for following through any RD's recommendation within 24 hours and RD's recommendations should have been followed through with the physician to address the problem and prevent further weight loss. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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	555671	A. Building B. Wing	02/23/2026

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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** 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 access for one of 12 final sampled residents (Resident 37). * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented upon admission in the medical records for Resident 37. This failure had the potential to delay the identification of catheter related complications for the resident.Findings: Review of the facility's P&P titled PICC Line (Peripherally Inserted Central Catheter) revised date 4/2025 showed, the facility ensures safe insertion, maintenance, and removal of PICC lines using infection prevention practices to prevent bloodstream infections and ensure resident safety. The purpose is to standardize PICC care, prevent infection, promote staff competency, and ensure CMS compliance. Medical record review for Resident 37 was initiated on 2/17/26. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed a physician's order dated 1/23/26, to measure arm circumference and to measure external catheter length every seven days. Review of Resident 37's Licensed Progress Note dated 1/24/26, failed to show the information of the measurement and assessment of the PICC line was documented when the resident was admitted to the facility. Review of Resident 37's H&P examination dated 1/26/26, showed Resident 37 had the capacity to understand and make decisions. Review of Resident 37's care plan date initiated 1/26/26, showed the resident had a PICC line on left upper arm with double lumens. The care plan interventions included to measure arm circumference and measure external catheter length every seven days. Review of the IV Administration Record for January 2026 failed to show the measurement of the PICC line was documented when the Resident 37 was admitted to the facility. Further review of Resident 37's medical record failed to show documented evidence the measurements of the length of the PICC line catheter above the insertion site and arm circumference were obtained upon admission. On 2/19/26 at 1424 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified Resident 37's medical record did not show the PICC line external catheter and arm circumference measurements upon admission to the facility. RN 1 stated there should have been a measurement of the length of the catheter and arm circumference upon admission of the resident. In addition, RN 1 stated the arm circumference measurement will indicate signs and symptoms of infection such as dislodgement, infiltration, swelling, pain and will ensure baseline information was available. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for one of 12 final sampled residents (Resident 43) reviewed for oxygen therapy. * The facility failed to ensure Resident 43's oxygen tubing was labeled and dated. This failure had the potential to place the resident at risk of receiving improper respiratory care. Findings: Review of the facility's P&P titled Oxygen Administration date revised 10/2025 showed the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Assemble the equipment and supplies as needed. On 2/17/26 at 0941 hours, during the initial tour of the facility, Resident 43 was observed lying in bed and receiving oxygen at 3 LPM via CPAP mask which was attached to the oxygen machine concentrator. In addition, the oxygen tubing was undated and unlabeled. Medical record review for Resident 43 was initiated on 2/18/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's Order Summary Report showed the following physician's orders:- dated 1/23/26 showed to change oxygen tubing every week and as needed; and- dated 1/26/26, for oxygen administration via nasal cannula at three LPM continuously. Review of Resident 43's care plan date initiated 1/24/26, showed the resident used of oxygen due to episodes of difficulty breathing. The interventions/ tasks included to administer oxygen inhalation as ordered and change oxygen tubing every week and as needed. Review of Resident 43's H&P examination dated 1/26/26, showed Resident 43 had the capacity to understand and make decisions. On 2/18/26 at 1610 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified Resident 43's oxygen tubing was unlabeled and undated. LVN 3 stated the oxygen tubing should have been labeled and dated for infection control purposes. On 2/19/26 at 1535 hours, an interview and concurrent medical record review for Resident 43 was conducted with RN 1. RN 1 was informed of the above findings and acknowledged and stated licensed nurses were responsible for changing the oxygen tubing weekly and it should have been labeled and dated for infection control purposes. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings.

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	555671	A. Building B. Wing	02/23/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, medical record review, and facility P&P review, the facility failed to provide adequate pain management for two of two final sampled residents (Residents 21 and 56) reviewed for pain management. * The facility failed to ensure Resident 21 was administered oxycodone (narcotic analgesic) medication as per the physician's order. In addition, the facility failed to monitor Resident 21's sedation level, BP, and apical pulse per the physician's order related to the administration of oxycodone medication. * Resident 56's ordered pain scale did not match the facility's standardized pain scale. In addition, the resident was administered PRN pain medication for a pain level of 5, which was below the ordered pain level of 6-10. These failures had the potential for Residents 21 and 56 to not receive effective treatment for pain.1. Review of the facility's P&P review titled Pain Assessment and Management dated 10/2025 showed the following: - Possible physiological signs of pain, including increased BP, tachycardia, increased respirations, diaphoresis, anorexia, or somnolence; - Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include environmental (adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc., physical (ice packs, cool or warm compresses, baths, TENS, massage, acupuncture, etc., exercise (range of motion exercise to prevent muscle stiffness and contractures), and cognitive or behavioral (relaxation, music, diversions, activities, etc.); - The medication regimen is implemented as ordered; and - Document the resident's reported level of pain with adequate detail as necessary and in accordance with the pain management program. Medical record review for Resident 21 was initiated on 2/17/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's Order Summary Report showed the following physician's order dated 5/2/25: - To administer acetaminophen (over-the-counter pain reliever) 325 mg two tablets by mouth every six hours as needed for mild pain 1 to 3/10 pain level; - To administer oxycodone-acetaminophen 5-325 mg one tablet every four hours as needed for moderate to severe pain, 4 to 10/10 pain level; - To monitor and assess pain every shift using pain scale as follows: 0 = no pain, 1 to 4 = mild pain; 5 to 7 = moderate pain; and 8 to 10 = severe pain; - For pain medication non-pharmacological interventions code: (1) repositioning, (2) dim light/ quiet environment, (3) hot/cold applications, (4) relaxation techniques, (5) distraction, (6) music, (7) massage, as needed; - To monitor blood pressure, apical pulse, and respiratory rate as needed for oxycodone-acetaminophen use; and (continued on next page)

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	555671	A. Building B. Wing	02/23/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- To monitor pain medication sedation level: (0) sleeping, (1) alert, (2) occasionally drowsy, easy to arouse, (3) frequently drowsy, arousable, (4) minimal or no response as needed. Review of Resident 21's MAR for January and February 2026 showed Resident 21 was administered the oxycodone medication on the following dates: - On 1/2/26 at 0300, 1300 and 1705 hours, Resident 21 was documented with a pain level of 6 to 8/10 pain level; - On 1/3/26 at 1640 hours, Resident 21 was documented with a pain level of 0/10; - On 1/4/26 at 0451 and 1850 hours, Resident 21 was documented with a pain level of 0/10; - On 1/5/26 at 2000 hours, Resident 21 was documented with a pain level of 0/10; - On 1/7/26 at 2104 hours, Resident 21 was documented with a pain level of 7/10; - On 1/9/26 at 1118 hours, Resident 21 was documented with a pain level of 9/10; - On 1/10/26 at 0400 hours, Resident 21 was documented with a pain level of 6/10; - On 1/12/26 at 0935 hours, Resident 21 was documented with a pain level of 8/10; - On 1/13/26 at 1637 hours, Resident 21 was documented with a pain level of 10/10; - On 1/14/26 at 0001 hours, Resident 21 was documented with a pain level of 7/10; - On 1/15/26 at 0802 and 1830 hours, Resident 21 was documented with a pain level of 8 and 7/10; - On 1/16/26 at 1106 and 1610 hours, Resident 21 was documented with a pain level of 8 and 6/10; - On 1/17/26 at 2030, Resident 21 was documented with a pain level of 6/10; - On 1/19/26 at 1037 and 1835 hours, Resident 21 was documented with a pain level of 8 and 0/10; - On 1/20/26 at 1230 hours, Resident 21 was documented with a pain level of 8/10; - On 1/21/26 at 0130 and 0923 hours, Resident 21 was documented with a pain level of 6 and 8/10; - On 1/23/26 at 0819 and 1536 hours, Resident 21 was documented with a pain level of 7 and 6/10; - On 1/26/26 at 1000 hours, Resident 21 was documented with a pain level of 8/10; - On 1/27/26 at 0030, 0910 and 1700 hours, Resident 21 was documented with a pain level of 6, 0, and 8/10; - On 1/28/26 at 0440 hours, Resident 21 was documented with a pain level of 0/10; - On 1/30/26 at 1230 hours, Resident 21 was documented with a pain level of 7/10; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 1/31/26 at 2100 hours, Resident 21 was documented with a pain level of 6/10; - On 2/3/26 at 1900 hours, Resident 21 was documented with a pain level of 0/10; - On 2/4/26 at 0019 and 1010 hours, Resident 21 was documented with a pain level of 5 and 8/10; - On 2/5/26 at 0808 and 1908 hours, Resident 21 was documented with a pain level of 8/10; - On 2/8/26 at 0826 and 1600 hours, Resident 21 was documented with a pain level of 8 and 6/10; - On 2/13/26 at 1900 hours, Resident 21 was documented with a pain level of 7/10; - On 2/14/26 at 0600 hours, Resident 21 was documented with a pain level of 6/10; - On 2/16/26 at 2000 hours, Resident 21 was documented with a pain level of 0/10; - On 2/17/26 at 1300 hours, Resident 21 was documented with a pain level of 8/10; and - On 2/18/26 at 0929 hours, Resident 21 was documented with a pain level of 8/10. Further review of Resident 21's MAR for January and February 2026 showed the following: - Non-pharmacological interventions were not provided prior to the administration of oxycodone medication on 1/ 2, 1/9, 1/10, 1/13, 1/14, 1/21, 1/28, 2/13, 2/14, and 2/18/26; - Resident 21's sedation level was not monitored on 1/ 2, 1/3, 1/4, 1/5, 1/9, 1/10, 1/13, 1/14, 1/21, 1/28, 2/3, 2/4, 2/14, 2/16, and 2/18/26; and - Resident 21's BP and apical pulse were not monitored when the oxycodone medication was administered to the resident. On 2/20/26 at 1424 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 2. RN 2 verified the oxycodone medication was prescribed for moderate to severe pain, 4 to 10/10 pain level. RN 2 verified the oxycodone medication was administered to Resident 21 with 0/10 pain level, and further verified Resident 21 was not provided with non-pharmacological interventions prior to the administration of the oxycodone medication, and Resident 21 was not monitored for sedation, BP and apical pulse when the oxycodone medication was administered to the resident. On 2/23/26 at 1330 hours, the DON and the Administrator were informed and acknowledged the above findings. 2. Review of the facility's Pain Assessment and Management P&P Revised October 2025 showed pain medication will be administered as ordered. Medical record review for Resident 56 was initiated on 2/17/26. Resident 56 was admitted to the facility om 2/13/26. Review of Resident 56's Order Summary Report showed the following orders:- dated 2/16/26, to (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer hydrocodone-acetaminophen 5-325 mg (a controlled pain medication), to administer one tablet by mouth every four hours PRN for moderate to severe pain, a pain level 6-10 out of 10 (on a pain scale with zero being no pain and 10 being most severe pain.); and- dated 2/13/26, to monitor and assess the resident's pain level every shift, with zero for no pain, 1-4 for mild pain, 5-7 for moderate pain, and 8-10 for severe pain. Review of Resident 56's MAR for February 2026, showed Hydrocodone-acetaminophen 5-352 mg was administered to the resident on 2/18/26 at 2155 hours, for a pain level of five (not the ordered pain level of 6-10). On 2/20/26, at 1455 hours, an interview and concurrent medical record review for Resident 56 was conducted with the DON. The DON stated the facility uses a standardized pain level for all residents, which is a pain level of 1-3 for mild pain, 4-6 or moderate pain, and 7-10 for severe pain. The DON reviewed Resident 56's medical records and verified the resident's pain level for her hydrocodone-acetaminophen order and pain monitoring for every shift does not match the facility's standard pain scale, and should be revised. The DON also reviewed the MAR and verified the hydrocodone- acetaminophen administered on 2/16/26, was administered below the ordered pain level parameter and should not have been administered for a pain level of 5 until the order was clarified.

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate dialysis care was provided for one of two final sampled residents (Resident 9) reviewed for dialysis services. * The facility failed to ensure the emergency dialysis kit kept at bedside was complete and contained a scissor clamp for Resident 9. This failure posed the risk of possible medical complications for Resident 9. Findings: Review of the facility's P&P titled Dialysis Care revised dated 5/11/25, showed to keep dialysis emergency kit at bedside in case of bleeding from the shunt site/ dialysis catheter. Medical record review for Resident 9 was initiated on 2/18/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 1/22/26, showed Resident 9 had no capacity to understand and make decisions. In addition, Resident 9 had a diagnosis of ESRD and was on renal dialysis. Review of Resident 9's care plan date initiated 1/21/26, showed the resident had a central vein catheter to right upper chest. Under interventions showed to apply pressure dressing to bleeding access site as necessary and notify the physician. If pressure dressing is ineffective, use clamp to stop the bleeding and notify the physician immediately. Review of Resident 9's Order Summary Report for 2/2026 showed the following physician's orders:- dated 1/20/26, to inspect dialysis site (right upper chest) for color, warmth, redness, edema, and/ or bleeding every shift. Keep pressure dressing at bedside.- dated 1/26/26, for hemodialysis every Tuesday, Thursday, and Saturday outside the facility. On 2/19/26 at 0947 hours, an observation and concurrent interview was conducted for Resident 9 with LVN 1. A dialysis emergency kit was available in Resident 9's room in a large zip lock bag labeled as dialysis kit. The dialysis emergency kit contained gauze dressing and a roll of paper tape however, there was no scissor clamp included in the dialysis kit. LVN 1 verified the above findings. LVN 1 stated the dialysis kit was incomplete and did not include a clamp scissor. On 2/19/26 at 1452 hours, an interview and concurrent medical record review was conducted for Resident 9 with RN 1. RN 1 was informed and acknowledged the above findings. RN 1 stated the dialysis kit should have included a clamp scissor. On 2/23/26 at 1537 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled resident (Resident 43) reviewed for the side rail use remained free from the accident hazards associated with the use of the elevated side rails. * The facility failed to ensure the physician's order was obtained for the use of bilateral half side rails for Resident 43. * The facility failed to ensure a care plan was developed to address the use of bilateral half side rails for Resident 43. * The facility failed to ensure the side rail assessment and the least restrictive interventions were completed prior to the use of bilateral half side rails for Resident 43. These failures had the potential risk for serious injury to the resident.Findings: Per the FDA's Safety Alert titled Entrapment Hazards with Hospital Bed Side Rails dated 1995, residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Bed Safety and Bed Rails revised 8/2025 showed the following:- The resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met;- The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent; and- If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes an evaluation of the alternatives to bed rails which were attempted and how these alternatives failed to meet the resident's needs, resident's risk associated with the use of bed rails, input from the resident and/or representative and consultation with the attending physician. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered date revised 3/2025 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. On 2/17/26 at 0941 hours, during the initial tour, Resident 43 was observed lying in bed, awake, oriented to name and verbally responsive. Resident 43's bed had bilateral half side rails elevated at the head of the bed. Medical record review for Resident 43 was initiated on 2/18/26. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 1/26/26, showed Resident 43 had the capacity to understand and make decisions. Review of Resident 43's Order Summary Report for 2/2026 failed to show a physician's order for the use of bilateral half side rails. Review of Resident 43's plan of care failed to show a care plan intervention for the use of bilateral half side rails. Further review of Resident 43's medical record failed to show a side rail assessment was completed. Additionally, there was no documented evidence the least restrictive alternatives were attempted prior to the use of side rails. On 2/18/26 at 1610 hours, an observation, interview, and concurrent medical record review for Resident 43 was conducted with LVN 3. LVN 3 acknowledged the findings. LVN 3 stated there should be a side rail recommendation from rehab, a physician's order, side rail assessment, informed consent, and care plan to verify the need of side rails and to prevent entrapment. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings. Cross reference to F909, example # 3.

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	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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **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 Pharmacy Consultant's recommendations from drug regimen review in January 2026 were acted upon for one of five final sampled residents (Resident 7) reviewed for pharmacy services. * The facility failed to ensure the drug regimen review recommendations of trying and documenting non-pharmacological interventions for January 2026 were acted upon for Resident 7. This failure placed the resident at risk for receiving unnecessary medications, increasing their risk for side effects.Findings: Review of the facility's P&P titled Psychoactive/ Behavior Assessment (undated) showed, prior to the use of Psychoactive medication the Interdisciplinary Team (IDT) assess the medical necessity/ how use of the Psychoactive medication would treat the medical symptoms and there should be a documented trial of alternatives (non-pharmacological intervention/ NPI). Review of the facility's P&P titled Psychotropic Medication Use dated 7/2025 showed drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Antipsychotics; b. Antidepressants; c. Antianxiety medications; and d. Hypnotics. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. Medical record review for Resident 7 was initiated on 2/17/26. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 7's Order Summary Report showed a physician's order dated 1/12/26, for depression non-pharmacological intervention record: 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 every shift. Review of Resident 7's H&P examination dated 1/13/26, showed Resident 7 had fluctuating capacity to understand and make decisions therefore, care was discussed with the spouse. Review of Resident 7's Consultant Pharmacist's Medication Regimen Review dated 1/23/26, showed a recommendation from the Pharmacy Consultant to try or document non-pharmacological interventions before medication administration. Review of Resident 7's MAR for January and February 2026 failed to show documented evidence non-pharmacological interventions were attempted prior to the administration of Resident 7's mirtazapine and trazodone medications. Further review of Resident 7's medical record showed no documented evidence the pharmacy consultant's recommendations were addressed. On 2/23/26 at 1008 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 acknowledged the above findings for Resident 7 and stated the pharmacist comes every month and reviews the medications of the residents. RN 1 stated the pharmacist provides recommendations and licensed nurses follows through within 72 hours. In addition, RN 1 stated non-pharmacological interventions should have been provided to the resident to evaluate the need and limit the use of the antidepressant medications. On 2/23/26 at 1537 hours, the DON was informed and verified the above findings. Cross reference to F605.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 maintain an accurate medical record for one of 12 final sampled residents (Resident 56). * The facility failed to ensure the Resident 56's pain level monitoring for each shift was accurately documented. This failure resulted in inaccurate medical records. Findings: Review of the facility's P&P titled Charting and Documentation revised July 2025 showed the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care, documentation will be complete and accurate. Medical record review for Resident 56 was initiated on 2/17/26. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's Order Summary Report showed a physician's order dated 2/13/26, to monitor and assess the resident's pain level every shift, with zero for no pain, 1-4 for mild pain, 5-7 for moderate pain, and 8-10 for severe pain. Review of Resident 56's MAR for February 2026 showed the resident's monitored pain level was documented as zero for all shifts (day, evening, and night shift) since her admission. However, on the following dates and times, the resident was administered pain medication due to pain:- On 2/14/26, at 0320 hours, tramadol HCl (a controlled pain medication) 50 mg was administered for a pain level of 5.-On 2/14/26, at 0828 hours, tramadol HCl 50 mg was administered for a pain level of 5. -On 2/14/26, at 2145 hours, tramadol HCl 50 mg was administered for a pain level of 7.-On 2/15/26, at 0720 hours, tramadol HCl 50 mg was administered for a pain level of 5.-On 2/15/26, at 1140 hours, tramadol HCl 50 mg was administered for a pain level of 5.-On 2/16/26, at 0500 hours, tramadol HCl 50 mg was administered for a pain level of 6.-On 2/18/26 at 2155 hours, hydrocodone-acetaminophen (a controlled pain medication) 5-352 mg was administered for a pain level of five. -On 2/20/26 at 0100 hours, hydrocodone-acetaminophen 5-352 mg was administered for a pain level of six. On 2/20/26, at 1455 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the pain level monitoring each shift, the highest level of pain for the shift was documented. The DON reviewed Resident 56's MAR and verified the pain level monitoring for each shift showed the resident had no pain, while the resident received PRN pain medications for pain levels five and above. The DON stated the licensed nurses for the corresponding shifts should have documented the highest pain level, and not zero.

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	555671	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to monitor and address the use of the antibiotics for one final sampled resident (Resident 51) and one non-sampled resident (Resident 40) reviewed for antibiotic stewardship. * The facility failed to ensure the McGeer's criteria assessment was completed in a timely manner for Residents 40 and 51 when the residents were started with antibiotics. This failure had the potential for the antibiotics to be used when they were not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled Antibiotic Stewardship revised 1/2025 showed the following under the Policy Interpretation and Implementation section:- Prior to calling a physician/prescriber to communicate a suspected infection, the nurse will obtain and have the following information available:Clinical signs and symptoms of suspected infection (based on approved definitions of infection by using the McGeer's criteria);A history of the present illness;Resident's hydration status;Current medication list;Allergy information;Any orders for warfarin and result of last INR;Last creatinine clearance or serum creatinine, if available; andTime of the last antibiotic dose.- Appropriate indications for the use of antibiotics include:Criteria met for clinical definition of active infection or suspected sepsis (McGreer's criteria); andPathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).- Empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record. 1. Medical record review for Resident 40 was initiated on 2/18/26. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's Order Summary Report showed a physician's order dated 2/3/26, to administer vancomycin hydrochloride (antibiotic) solution, give one gram intravenously every 36 hours for MRSA bacteremia secondary to lumbar wound infection for 38 days. Review of Resident 40's IV Administration Record for February 2026 showed Resident 40 received the vancomycin medication on 2/4, 2/6, 2/7, 2/9, 2/10, 2/12, 2/13, 2/15, and 2/16/26. 2. Medical record review for Resident 51 was initiated on 2/18/26. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Order Summary Report showed the following physician's orders:- dated 2/7/26, to administer diflucan (antifungal medication used to treat infections caused by yeast or fungus) oral tablet, give 150 mg one dose by mouth one time only for UTI (urinary tract infection) until 2/7/26 at 2359 hours from E-Kit; and- dated 2/9/26, to administer diflucan oral tablet, give 150 mg one tablet by mouth one time a day for yeast infection of urine until 2/12/26 at 2359 hours times three doses. Review of Resident 51's MAR for February 2026 showed Resident 51 received the diflucan medication on 2/7/26 at 1720 hours, and on 2/10, 2/11, and 2/12/26 at 0900 hours. On 2/19/26 at 1616 hours, an interview, concurrent medical record review for Residents 40 and 51, and facility document review were conducted with the IP. The IP stated she would be notified if there was a new order of antibiotics for residents during their daily change of condition huddle, reviewing the newly admitted resident's medical records, reviewing the SBARs completed by the nurses when there was a new order for antibiotics for the residents when asked how did she know when to review the use of antibiotics for the residents. The IP stated after she reviewed the resident's medical record, she would also assess the resident then she would complete the Infection Surveillance Review form to determine if the resident met the criteria for the use of antibiotics. The IP stated the facility followed McGeer's criteria for the surveillance of infections. The IP stated she would complete infection surveillance review as soon as possible because if the resident did not meet the criteria for the use of antibiotics, she had to notify the physician. Review of the facility's document titled Infection Surveillance Review for February 2026 did not show evidenced the infection surveillance review were completed for Residents 40 and 51 to determine if the residents met the criteria for the use of antibiotics when the residents were started on antibiotics. The IP verified the findings. On 2/23/26 at 1431 hours, an (continued on next page)

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 40 and 51.

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	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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure the glucometer in Medication Cart A, and the refrigerators used to store medications in Medication Rooms A and B were maintained in a safe operating condition. * The facility failed to ensure the glucometer calibration was conducted for the glucometer in Medication Cart A. Furthermore, the facility failed to ensure the glucose strips and control solutions had an expiration date of 90 days after opening, as per the manufacturer's information. * The facility failed to ensure the freezer compartment inside the refrigerator used for medications in Medication Room A was free of ice buildup. This had the potential to affect the refrigerator's functionality and the potentially affect the potency of the medications stored inside the refrigerator. These failures had the potential for the essential equipment to not function in the way it was intended and expose the residents to unsafe practices. Findings: 1. Review of the blood glucose meter manufacturer's information sheet titled Quality Assurance/ Quality Control Reference Manual revised 12/2017 under the Troubleshooting Control Procedure section, showed to make sure the test strips and control solutions are not past expiration date. The date is shown in the bottle. Discard control solution 90 days after the bottle is opened; and results that fall outside the range may be caused by the test strip bottle was opened for more than three months. On 2/17/26 at 1522 hours, an inspection of Medication Cart A, interview and concurrent facility document review was conducted with RN 3. The following was observed inside Medication Cart A: a glucometer quality control with serial number 1040-4437454, two bottles of glucometer strips with lot number 635235U, with an opened date of 2/15/26, and bottles of the normal and high control solutions, with opened date of 2/4/26. Review of the facility's document titled Blood Glucose Monitoring Quality Control Record for February 2026 showed the following:- A glucometer serial number 1040-4437455 as documented in the record did not match the serial number of the glucometer;- The glucometer strip lot number 635115U, with an expiration of 4/15/27 as documented in the record did not match the opened glucometer strip lot number; - The control solution was documented with an expiration date of 6/18/27, and- The high control solution range of 215 to 269 as documented in the record did not match the high control solution range as shown in the glucometer strip bottle. RN 3 verified the above findings. On 2/17/26 at 1617 hours, an interview and concurrent facility document review was conducted with RN 2. RN 2 verified the above findings. When asked about the expiration dates of the glucometer strips and the control solutions, RN 2 stated she was not sure if the facility went by the expiration dates printed on the box, 30 or 90 days from the opening date. RN 2 verified the expiration dates of the glucometer strips and control solutions as documented on the Blood Glucose Monitoring Quality Control Record were not 90 days from the date of opening. 2. Review of the facility's P&P titled Storage of Medications revised 5/2025 showed the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. On 2/20/26 at 0821 hours, an inspection of the refrigerators used to store medications inside Medication Rooms A and B, and concurrent interview was conducted with RN 2. The following was observed:-The refrigerator in Medication Room A was observed with build-up of ice, and brown stain on the side of the freezer; and-The refrigerator in Medication Room B was observed with build-up of ice. RN 2 verified the above findings. RN 2 stated the licensed nurses could clean the refrigerator, unless, it was something technical then the licensed nurses called the maintenance department. On 2/23/26 at 1056 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the maintenance department cleaned the refrigerators used to store medications monthly, but the licensed nurses could always call the maintenance department to clean before the scheduled monthly cleaning. On 2/23/26 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.