| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555738 | A. Building<br>B. Wing | 04/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Terrace Post Acute | 7447 Sepulveda Blvd<br>Van Nuys, CA 91405 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of three sample residents (Resident 1 and Resident 2) received PRN (as needed) medication as prescribed by the ordering physician by:1. Failing to ensure Resident 1's PRN Ketorolac Tromethamine Solution (medication [eye drops] used to treat pain, inflammation or itching) eye drop was available at the time Resident 1 requested the medication.2. Failing to ensure Resident 2's PRN acetaminophen (medication used to treat mild to moderate pain) tablet 325 milligrams (mg- unit of measurement) two tablets were administered as ordered by the physician.These deficient practices had the potential to delay necessary treatment, care and services, increased levels of discomfort, placing Resident 1 and Resident 2 at risk for a decline in overall health status.1. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on [DATE] with diagnoses that included quadriplegia (paralysis [partial or complete loss of voluntary muscle function in a body part] from the neck down, including legs, and arms, usually due to a spinal cord injury), hypotension (low blood pressure) and anxiety disorder (a feeling of fear, dread and uneasiness that interferes with daily functioning).During a review of Resident 1's Physician Order dated [DATE], the Physician Order indicated Ketorolac Tromethamine Solution 0.4%, with instructions to instill one (1) drop in both eyes every eight hours as needed for itchy eyes.During a review of Resident 1's History and Physical (H&P- a comprehensive assessment of a resident's medical condition) dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 was dependent on staff for activities of daily living (ADL- routine tasks or activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an interview on [DATE] at 11:10 a.m., with Resident 1, Resident 1 stated that earlier in the month (unable to recall the exact date), Resident 1 requested Ketorolac Tromethamine and was informed the facility does not have eye drops available at that time. Resident 1 stated that the nurse informed Resident 1 that the medication (Ketorolac Tromethamine) would need to be ordered from the pharmacy.During an interview on [DATE] at 12:30 p.m., with Registered Nurse (RN) 1, RN 1 stated that Resident 1 does have a physician order for Ketorolac Tromethamine PRN for itchy eyes. RN 1 stated that when Resident 1 requested Ketorolac Tromethamine, it was not available and had to be ordered from the pharmacy. RN 1 further stated that Ketorolac Tromethamine expires 28 days after opening. RN 1 stated that the nursing staff should have re-ordered the medication prior to expiration to ensure availability when needed.2. During a review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on [DATE] with the most recent readmission on [DATE] with diagnoses that include spinal stenosis (narrowing of spaces within the spine, causing pressure on the spinal cord or nerves, commonly resulting in pain), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), fusion of spine (a surgical procedure that permanently connects two or more bones in the back into a single solid spinal bone), low back pain, (continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | muscle weakness and difficulty in walking.During a review of Resident 2's Physician Order Summary dated [DATE], the Physician Order Summary indicated a physician's order for acetaminophen 325 milligrams oral tablet, with instructions to administer two tablets by mouth every six hours as needed for mild pain, one to four out of 10 scale (on the numeric pain rating scale [a pain assessment tool that uses a scale ranging from zero {0- no pain} to 10 {worst pain imaginable} to quantify pain intensity), Tylenol (brand name for acetaminophen) not to exceed three grams (gm- a unit of measurement) in 24 hours from all sources.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS further indicated Resident 2 was independent with eating, oral hygiene, and personal hygiene. Resident 2 required supervision for toileting hygiene, showering, upper and lower body dressing.During a review of Resident 2's Medication Administration Record (MAR - legal report used in healthcare to document the specific medications given to a resident) dated [DATE], the MAR indicated that on [DATE], Registered Nurse Supervisor 1 (RNS 1) administered acetaminophen oral tablet 325 mg, two tablets, for a reported pain level of 6 out of 10. During an interview on [DATE] at 3:50 p.m., with RNS 1, RNS 1 stated that RNS 1 did administer acetaminophen oral tablet 325 mg, two tablets to Resident 2 for pain. RNS 1 stated that the physician order for Resident 2 indicated acetaminophen 325mg, two tablets for a pain level of one to four out of 10 for mild pain. RNS 1 stated that Resident 2's pain level was greater than 4 and that the acetaminophen should not have been administered to Resident 2 on [DATE].During an interview on [DATE] at 2:15 p.m., with the Director of Nursing (DON), the DON stated that the facility should have PRN medications available for residents as ordered by the physician. The DON stated that the nursing staff should have ordered Resident 1's Ketorolac eye drop when the previous Ketorolac eye drops expired and have it available for Resident 1 when needed. The DON further stated that RNS 1 should have followed the physician's order and should have not administered acetaminophen 325mg two tablets for a pain level of six out of 10. During a review of the facility's policy and procedure (P&P) titled Administering Medications last reviewed on [DATE], the P&P indicated medications are administered in a safe and timely manner and as prescribed.medications are administered in accordance with prescriber orders, including any required time frame.During a review of the facility's P&P titled Pain Management last reviewed on [DATE], the P&P indicated the purpose of the policy is to maintain the highest possible level of comfort for Residents by providing a system to identify, assess, treat, and evaluate pain.pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences is provided to Residents who require such services. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that one of three sampled residents (Resident 2) had an accurate Medication Regimen Review (MRR- a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcome and minimizing adverse consequences and potential risk associated with medication completed by the consulting pharmacist) when the facility Pharmacist Consultant 1 (PC 1) did not identify and report that Resident 2 had multiple physician orders for acetaminophen (a medication used to treat mild to moderate pain levels) for pain management.This deficient practice had the potential to result in Resident 2 exceeding the recommended maximum dose of acetaminophen within a 24-hour period (four grams [gm-unit of measurement]), increasing the risk of liver impairment and decline in overall health status.During a review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on 10/15/2025 with the most recent readmission on [DATE] with diagnoses that include spinal stenosis (narrowing of spaces within the spine, causing pressure on the spinal cord or nerves, commonly resulting in pain), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), fusion of spine (a surgical procedure that permanently connects two or more bones in the back into a single solid spinal bone), low back pain, muscle weakness and difficulty in walking.During a review of Resident 2's Physician Order Summary dated 1/17/2026, the Physician Order Summary indicated a physician's order for acetaminophen 325 milligrams oral tablet, with instructions to administer two tablets by mouth every six hours as needed for mild pain, one to four out of 10 scale (on the numeric pain rating scale [a pain assessment tool that uses a scale ranging from zero {0- no pain} to 10 {worst pain imaginable} to quantify pain intensity), Tylenol (brand name for acetaminophen) not to exceed three grams (gm- a unit of measurement) in 24 hours from all sources. A second physician order dated 1/17/2026 indicated acetaminophen 500 mg oral tablets, with instructions to administer two tablets by mouth every eight hours (routinely) for pain management, not to exceed three grams in a 24 hour period from all sources. A third physician order dated 1/15/2026 indicated hydrocodone-acetaminophen (a narcotic medication used for moderate to severe pain) Oral Tablet 5mg-325mg, with instructions to administer one tablet by mouth every 4 hours as needed for moderate pain five to seven out of 10 scale, not to exceed three grams of acetaminophen per day.During a review of Resident 2's Medication Administration Record (MAR- a facility form used to track the administration of medications for residents) dated January 2026, the MAR indicated Resident 2 began receiving acetaminophen 500 mg oral tablets, two tablets every eight hours on 1/13/2026, totaling 3000 mg in a 24-hour period. The MAR further indicated that hydrocodone-acetaminophen 5mg-325mg was administered on 1/15/2026, 1/18/2026, 1/24/2026, 1/25/2026, 1/29/2026 and 1/30/2026, resulting in total daily acetaminophen doses exceeding 3,000 mg per day. During a review of Resident 2?s MAR dated February 2026, the MAR indicated Resident 2 continued to receive acetaminophen 500mg oral tablets, two tablets every day, totaling 3,000 mg per day. The MAR further indicated Resident 2 received hydrocodone-acetaminophen oral tablet 5mg-325mg on multiple dates including 2/1/2026, 2/3/2026 through 2/6/2026, 2/8/2026 through 2/12/2026, 2/14/2026 through 2/18/2026 and 2/20/2026 through 2/28/2026, resulting in total daily acetaminophen doses exceeding 3,000 mg per day.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS further indicated Resident 2 was independent with eating, oral hygiene, and personal hygiene. Resident 2 required supervision for toileting hygiene, showering, upper and lower body dressing.During a review of Resident 2's MAR dated March 2026, the MAR indicated Resident 2 received acetaminophen oral tablet 500mg 2 tablets every day, a total 3000mg daily. MAR further indicated Resident 2 received hydrocodone-acetaminophen oral tablet 5mg-325mg daily from 3/1/2026 to 3/31/2026.During a<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | review of Resident 2's MAR dated April 2026, the MAR indicated that from 4/1/2026 to 4/15/2026, Resident 2 continued to receive acetaminophen 500mg oral tablets, two tablets every day, totaling 3,000 mg per day. The MAR further indicated Resident 2 received hydrocodone- acetaminophen oral tablet 5mg-325mg daily from 4/1/2026 to 4/10/2026 and 4/12/2026 to 4/15/2026. Resulting in total daily acetaminophen doses exceeding the 3,000 mg.During a review of Resident 2's MRR dated 1/28/2026, the MRR indicated the facility Pharmacist Consultant (PC) 1 reviewed Resident 2's medications and no recommendations were needed.During a review of Resident 2's MRR dated 2/17/2026, the MRR indicated the facility PC 1 reviewed Resident 2's medications and no recommendations were needed.During a review of Resident 2's MRR dated 3/29/2026, the MRR indicated the PC 1 reviewed Resident 2's medications and no recommendations were needed.During an interview on 4/17/2026 at 11:35 a.m., with PC 1, PC 1 confirmed that she (PC 1) completed MRRs for residents at the facility. PC 1 stated she (PC 1) does not remember Resident 2 off the top of her head and would have to look at her notes. Upon review, PC 1 stated she (PC 1) had been under the impression that if Resident 2 received a PRN (as needed) medication containing acetaminophen, nursing staff would not give the routine acetaminophen dose in accordance with the physician's order not to exceed three grams per day. During a concurrent interview and record review on 4/21/2026 at 2:15 pm., with the Director of Nursing (DON), Resident 1's Physician's Orders dated 1/15/2026-1/17/2026 and MAR for 4/2026 were reviewed. The DON stated that Resident 2 was started on acetaminophen 1000 mg three times a day on 1/13/2026 by the pain management physician. The DON further stated that Resident 2 also had physician's orders for PRN acetaminophen 325 mg, two tablets for mild pain, one to four out of 10 scale, and hydrocodone-acetaminophen 5mg-325mg for moderate pain five to seven out of 10 pain scale as needed. The DON stated that the physician's order specified not to exceed three grams of acetaminophen per day from all sources. The DON stated that MRRs were completed monthly for Resident 2. The DON further stated that during the MRR process, PC 1 should have identified and notified the facility that Resident 2 was at risk of exceeding three grams of acetaminophen per day due to multiple physician orders for pain management.During a review of the facility policy and procedure (P&P) titled Medication Regimen Reviews last review date of 1/21/2026, the P&P indicated a licensed consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The purpose of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risk associated with medication. The MRR includes a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities, for example, the use of medication.potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences.The consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports. |