

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Terrace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7447 Sepulveda Blvd 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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain management was provided to residents who require such services consistent with professional standards of practice and the comprehensive person-centered care plan to three of five sampled residents (Residents 6, 109, and 11) investigated for pain management when: 1. The facility failed to ensure licensed nurses attempted nonpharmacological (treatments or therapies that do not involve the use of medications) pain interventions prior to administering as needed pain medication for Residents 6 and 109. 2. The facility failed to ensure Resident 11 was monitored for adverse side effects after receiving a narcotic pain medication (or known as an opioid, a strong prescription drug that relieves severe pain by blocking pain signals in the brain). These deficient practices had the potential to place Residents 6, 109, and 11 at an increased risk of experiencing adverse side effects from pain medication including drowsiness, constipation, and a decrease in respirations. Findings: 1. a. During a review of Resident 6's admission Record, the admission Record indicated the facility originally admitted the resident on 10/15/2025 and readmitted the resident on 11/2/2025 with diagnoses including, but not limited to, spinal stenosis (the narrowing of spaces within your spine, putting pressure on the spinal cord), low back pain, and difficulty in walking. During a review of Resident 6's History and Physical (H&P), dated 1/2/2026, the H&P indicated Resident 6 had the capacity to make decisions. During a review of Resident 6's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 11/9/2025, the MDS indicated the resident was cognitively intact (can think, learn, and remember clearly) and was totally dependent on staff or required substantial assistance (helper provides more than half the effort) for most activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) . During a review of Resident 6's Pain Evaluation, dated 11/2/2025, the Pain Evaluation indicated Resident 6 experienced pain to her lower back surgical site. During a review of Resident 6's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals), titled Resident exhibits or is at risk for alterations in comfort., last revised on 12/30/2025, the care plan indicated to offer nonpharmacologic interventions prior to as needed pain medication administration. During a review of Resident 6's physician's orders, Resident 6 had the following active orders: 1. Hydrocodone-Acetaminophen (a drug used to treat moderate to severe pain) 5-325 milligrams (mg), (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	give one tablet every four hours as needed for moderate pain, dated 11/3/2025. 2. Hydrocodone-Acetaminophen 5-325 milligrams (mg), give two tablets by mouth every four hours as needed for severe pain, dated 11/3/2025. 3. Document nonpharmacological interventions: a. Heat, b. Repositioning, C. Relaxation breathing, D. Food/Fluid, E. Massage, F. Exercise, G. Immobilization of joint, H. Other: write in progress note as needed. Document results ineffective (-) or effective (+), dated 11/2/2025. During a review of Resident 6's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated January 2026, the MAR indicated the resident was administered one hydrocodone-acetaminophen 5-325 mg tablet for moderate pain on the following dates and times: 1/5/2026 at 5:00 p.m., 1/6/2026 at 9:23 a.m. and 8:37 p.m., and 1/11/2026 at 10:50 a.m. Resident 6's MAR indicated the resident was administered two hydrocodone-acetaminophen 5-325 mg tablets for severe pain on the following dates and times: 1/2/2026 at 9:09 a.m. and 1/12/2026 at 2:19 p.m. The MAR did not indicate any nonpharmacological interventions were attempted at any time in January 2026. b. During a review of Resident 109's admission Record, the admission Record indicated the facility originally admitted the resident on 5/24/2019 and readmitted on [DATE] with diagnoses including, but not limited to, myocardial infarction (MI-heart attack), urinary tract infection (UTI- an infection in the bladder/urinary tract), and chronic (long-term) pain. During a review of Resident 109's H&P, dated 12/26/2025, the H&P indicated Resident 109 had the capacity to make decisions. During a review of Resident 109's MDS, dated [DATE], the MDS indicated the resident was cognitively intact and was totally dependent on staff or required substantial assistance for most ADLs. During a review of Resident 109's Pain Evaluation, dated 12/25/2025, the Pain Evaluation indicated Resident 109 experienced a level eight out of ten aching pain on the pain scale (a tool where residents rate pain intensity, with 0 being no pain and 10 being the worst possible pain). During a review of Resident 109's care plan, titled [Resident 109] is at risk for pain/discomfort., last revised on 10/13/2025, the care plan indicated to encourage the resident to try different pain-relieving methods like positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, and ultrasound. During a review of Resident 109's physician's orders, Resident 109 had the following active orders: 1. Tylenol 325 mg tablet. Give two tablets every 6 hours as needed for mild pain, dated 12/29/2025. 2. Tylenol Extra Strength 500 mg tablet. Give two tablets as needed for moderate pain, not to exceed 3 grams for a 24-hour period, dated 12/29/2025. 3. Oxycodone (a drug used to treat severe pain) 10 mg tablet. Give one tablet by mouth every four hours as needed for severe pain, dated 12/25/2025. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Document nonpharmacological interventions: a. Heat, b. Repositioning, C. Relaxation breathing, D. Food/Fluid, E. Massage, F. Exercise, G. Immobilization of joint, H. Other: write in progress note as needed. Document results ineffective (-) or effective (+), dated 12/25/2025. During a review of Resident 109's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated January 2026, the MAR indicated the resident was administered two Tylenol 325 mg tablets for mild pain on the following dates and times: 1/4/2026 at 1:16 p.m., 1/5/2026 at 1:11 p.m., and 1/13/2026 at 5:51 p.m. The MAR indicated the resident was administered two Tylenol Extra Strength 500 mg tablets for moderate pain on the following dates and times: 1/2/2026 at 9:11 p.m., 1/4/2026 at 9:46 p.m., 1/5/2026 at 3:02 p.m., and 1/11/2026 at 9:38 p.m. The MAR indicated the resident was administered one oxycodone 10 mg tablet for severe pain on the following dates and times: 1/1/2026 at 1:00 a.m., 5:00 a.m., 9:08 a.m., 1:08 p.m., 5:48 p.m., and 10:10 p.m.; 1/2/2026 at 2:10 a.m., 6:10 a.m., 10:55 a.m., 2:55 p.m., and 7:10 p.m.; 1/3/2026 at 12:55 a.m., 9:09 a.m., 1:15 p.m., 5:30 p.m., and 9:30 p.m.; 1/4/2026 at 1:58 a.m., 6:02 a.m., 11:01 a.m., 3:44 p.m., and 8:07 p.m.; 1/5/2026 at 12:06 a.m., 4:13 a.m., 8:33 a.m., 12:40 p.m., 4:58 p.m., and 9:00 p.m.; on 1/6/2026 at 1:02 a.m., 5:00 a.m., 9:06 a.m., 2:42 p.m., and 8:40 p.m.; on 1/7/2026 at 1:10 a.m., 5:10 a.m., 10: 25 a.m., 2:57 p.m., 7:00 p.m., and 11:00 p.m.; on 1/8/2026 at 4:00 a.m., 11:28 a.m., 3:48 a.m., and 7:49 p.m.; on 1/9/2026 at 12:24 a.m., 4:52 a.m., 10:10 a.m., and 2:15 p.m.; on 1/10/2026 at 3:10 a.m., 9:12 a.m., 1:18 p.m., 5:36 p.m., and 9:36 p.m.; on 1/11/2026 at 2:20 a.m., 6:37 a.m., 10:59 a.m., 3:00 p.m., and 7:03 p.m.; on 1/12/2026 at 1:00 a.m., 5:00 a.m., 9:44 a.m., 2:25p.m., 7:30 p.m., and 11:30 p.m.; and on 1/13/2026 at 3:31 a.m., 9:31 a.m., and 2:20 p.m. The MAR did not indicate any nonpharmacological interventions were attempted at any time in January 2026. During a concurrent interview and record review on 1/13/2026 at 4:18 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 6 and Resident 109s' MARs, dated January 2026, were reviewed. LVN 5 stated before giving a pain medication, other interventions to reduce pain like distraction, talking to the resident, adjusting their position, or offering a warm drink should be attempted. LVN 5 stated there was no documentation that nonpharmacological pain interventions had been attempted. LVN 5 stated nonpharmacological pain interventions should have been attempted because they (licensed nurses) are supposed to do them before giving a pain medication as there is a risk the residents could become dependent on the medications. During an interview on 1/15/2026 at 11:16 a.m. with the Assistant Director of Nursing (ADON), the ADON stated nonpharmacological interventions should be tried before giving medication. The ADON stated they (licensed nurses) should try the basics first and then medication might not be needed because there are risks to medications like drowsiness and other side effects. During a review of the facility's policy and procedure (P&P) titled Pain Management, last reviewed and updated on 1/16/2025, the P&P indicated the resident should have an individualized care plan including nonpharmacological interventions. The P&P indicated nonpharmacological interventions and their effectiveness should be documented. The P&P further indicated nonpharmacological interventions should be reviewed for their effectiveness. 2. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 4/03/2024 with diagnoses that included left femur fracture (left thigh fracture). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 12/24/2025, the document indicated Resident 11 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skills required for daily decision making. The MDS indicated Resident 11 was dependent (helper does all the effort) on staff with eating, oral hygiene, and upper body dressing. During a review of Resident 11's Physician's Orders, the orders indicated the following: -Norco oral tablet (narcotic pain medication) 5-325 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for pain management related to history of left femur fracture, dated 12/09/2025. -Norco oral tablet 5-325 mg, give one tablet by mouth every 24 hours as needed for breakthrough pain (a sudden episode of pain that occurs in residents with chronic pain, breaking through their regular pain management, exacerbations that occur above their baseline level), dated 12/09/2025. During a review of Resident 11's Pain Assessment, dated 12/24/2025, the assessment indicated Resident 11 does not currently have pain but will continue to observe pain or discomfort every shift and as needed. During a review of Resident 11's Care Plan (CP) for Pain, initiated on 10/17/2024, the CP indicated a goal that pain will be minimized after 30-60 minutes after intervention has been rendered. The care plan indicated an intervention to administer analgesia (pain relieve medication) as per orders and to monitor/document for side effects of pain medication. During a review of Resident 11's 12/2025 and 1/2026 Medication Administration Record, the record indicated there was no documentation regarding monitoring of side effects for Norco. The time period covered in the MARs included the dates 12/10/2025 through 1/13/2026. During a concurrent interview and record review with Registered Nurse 2 (RN 2), on 1/15/2026 at 8:50 a.m., RN 2 reviewed Resident 11's 12/2025 and 1/2026 MARs that covered the dates 12/10/2025 through 1/13/2026. RN 2 confirmed for Resident 11 there was no documentation of Resident 11 being monitored for side effects of the Norco administration. RN 2 stated it is important for the licensed nurses to monitor side effects such as respiratory depression and constipation (a condition in which stool becomes hard, dry, and difficult to pass). During a concurrent interview and record review with the Director of Nursing (DON) on 1/15/2026 at 9:07 a.m., the DON reviewed Resident 11's 12/2025 and 1/2026 MARs that covered the dates 12/10/2025 through 1/13/2026 and Resident 11's Care Plan for Pain. The DON stated Resident 11's care plan for pain should be followed. The DON stated to ensure adverse side effects for pain medication were being monitored, the licensed nurses would need to document the monitoring in a resident's MAR. The DON stated it is important for the licensed nurses to monitor for side effects such as respiratory depression and constipation. During a review of the facility's policy and procedure (P&P) titled, Pain Management, last reviewed 1/16/2025, the P&P indicated residents receiving interventions for pain will be monitored for the effectiveness and side effects (e.g. constipation, sedation) in providing pain relief. The policy indicated to document side effects, if present, and notification of physician. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care including the right to: receive the services and/or items included in the plan of care.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility: 1.Failed to have an available supply of Mounjaro (a medication used for Diabetes Mellitus 2 ([DM2] - a condition of having high blood sugar levels) in the medication cart, affecting one (1) of three (3) observed residents (Resident 128) during the medication administration task. As a result, Resident 128 did not receive Mounjaro on 1/12/2026 at 9 a.m. in accordance with the physician's orders and standards of practice. 2. Failed to reconcile (the process of comparing transactions and activity to supporting documentation) three (3) medication emergency kits ([eKITS] - kit containing medications needed during emergencies) containing Controlled Substances ([CS] - also known as Controlled Drug or Controlled Medications [CD, CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for January 2026, in one (1) of two (2) inspected medication rooms (Medication room [ROOM NUMBER]) As a result, control and accountability of CMs did not follow state and federal regulations and facility policy and procedures. 3. Failed to accurately document the administration of hydrocodone-acetaminophen (a combination CM used for pain, known as Norco) 10-325 milligram ([mg] - a unit of measure of mass) on the Medication Administration Record ([MAR - record of medications administered to a resident) on 1/12/2026, for one (1) of three (3) observed Residents (Resident 30) during the medication administration task. As a result, Resident 30 could not receive hydrocodone-acetaminophen 10-325 mg at the time of request. These deficient practices had the potential to cause Resident 30 to experience continued and worsening pain resulting in physical and psychosocial harm; for Resident 128 to experience serious health complications due to improper management of DM2, possibly resulting in uncontrolled blood sugar levels, hypoglycemia (low blood sugar level,) hyperglycemia (high blood sugar level,) and coma resulting in hospitalization and/or death; and increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, and hospitalization. Findings: During an observation on 1/12/2026 at 8:41 a.m., in Medication Cart 2, Licensed Vocational Nurse (LVN) 3 was observed inquiring Resident 30's pain level. Resident 30 stated pain level of seven (7). During an observation on 1/12/2026 at 8:58 a.m., LVN 3 was observed communicating to Resident 30 that LVN 3 was unable to administer hydrocodone-acetaminophen because it was too soon according to the last administration time of 7:20 a.m. Resident 30 stated the last dose administered was sometime after midnight. During a concurrent record review and interview, with LVN 3, the Antibiotic or Controlled Drug Record (also known as Narcotic Count Sheet), MAR and medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for hydrocodone-acetaminophen 10-325 mg was reviewed for January 2026 for Resident 30. The Antibiotic or Controlled Drug Record indicated there was 19 hydrocodone-acetaminophen 10-325 mg tablets remaining in the medication bubble pack after the last documented administration of hydrocodone-acetaminophen 10-325 mg tablet on 1/12/2026 at 1 a.m. by LVN 2. The MAR documentation indicated the last administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 was on 1/12/2026 at 7:20 a.m. by LVN 2. The medication bubble pack contained 19 hydrocodone-acetaminophen 10-325 mg tablets. LVN 3 stated the Antibiotic or Controlled Drug Record matches the number of tablets remaining in the medication bubble pack and validates Resident 30's statement that the last dose was given sometime after midnight. LVN 3 stated the MAR indicated no documentation for the administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 that morning (1/12/2026) at 1 a.m. by LVN 2. LVN 3 stated per facility policy the MAR should be documented immediately after the administration of the dose. LVN 3 stated LVN 2 documented the administration later at 7:20 a.m. instead. LVN 3 stated LVN 2 failed to (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow the facility's policy of documenting the administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 that morning (1/12/2026) at 1 a.m. on the MAR immediately after the administration of the dose. LVN 3 stated it was important to document each dose immediately after administration to ensure accurate records and prevent medication errors such as underdosing (giving less than the prescribed dose) or overdosing (giving more than the prescribed dose) of a harmful substance to Resident 30, which could lead to stoppage of breathing, hospitalization or death. During an observation on 1/12/2026 at 9:39 a.m., in Medication Cart 2, Licensed Vocational Nurse (LVN) 3 was observed not administering Mounjaro 0.5 milliliter ([ml] - a unit of measure of volume) injection to Resident 128. During an interview on 1/12/2026 at 10:26 a.m., with LVN 2, LVN 2 stated that LVN 2 failed document the administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 that morning (1/12/2026) at 1 a.m. on the MAR immediately after the administration of the dose. LVN 2 stated LVN 2 documented the administration at 7:20 a.m. instead leading to inaccurate records and preventing LVN 3 from administering a dose to Resident 30 around 9 a.m. LVN 2 stated that LVN 2 failed to follow facility policy of documenting administration of CM immediately after administration. LVN 3 stated if Resident 30 had not received a dose of hydrocodone-acetaminophen, then the resident would be subject to more pain, affecting quality of care. During an interview on 1/12/2026 at 10:30 a.m., with Resident 30, Resident 30 stated that LVN 2 administered a dose of hydrocodone-acetaminophen sometime after midnight on 1/12/2026. Resident 30 stated that she woke up between 6:30 a.m. and 7 a.m. that morning (1/12/2026) and her pain was 7. Resident 30 stated she did not alert the licensed staff and decided to request pain medication during the usual 9 a.m. medication administration. During an interview on 1/12/2026 at 1:25 p.m., with LVN 3, LVN 3 stated that LVN 3 did not administer Mounjaro 0.5 ml injection to Resident 128 at the 9 a.m. scheduled time that day (1/12/2026,) because the medication was not available in the medication cart or in the facility. LVN 3 stated LVN 3 will follow up with the pharmacy to expedite the delivery of Mounjaro and call the physician to inform the morning dose (on 1/12/2026) was not administered. LVN 3 stated that medications should be ordered from pharmacy, and followed up as needed, to ensure timely delivery and availability of medications. LVN 3 stated it was important to receive Mounjaro as ordered by the physician for DM 2, and skipping or delaying a dose can harm Resident 128 by causing high or low blood sugar levels, leading to coma and requiring hospitalization. During an observation on 1/13/2026 at 9:45 a.m., with LVN 4, in Medication room [ROOM NUMBER], there were three (3) medication eKITS stored in the refrigerator and labeled 187, 450 and 724, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for January 2026. During a concurrent interview, LVN 4 stated that all CMs, including medication eKITS containing CMs, should be reconciled at every shift. LVN 4 stated the three (3) eKITS labeled 187, 450 and 724 containing CMs in Medication room [ROOM NUMBER] refrigerator were not reconciled at every shift in January 2026, and it was important to account for all CMs to ensure accountability and prevent CM diversion.^^ During an interview on 1/13/2026 at 1:10 p.m., with the Director of Nursing (DON,) the DON stated that LVN 2 failed to follow facility policy of documenting the administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 on the MAR on 1/12/2026 immediately after giving the 1 a.m. dose. The DON stated not documenting the MAR immediately can lead to inaccurate records, and accidental use resulting in either overdose of harmful substances or underdose causing uncontrolled pain for Resident 30. During the same interview, the DON stated that medications should be readily available for administration at the scheduled times and as ordered by the physician. The DON stated that per that facility policy medications should be administered within a 60-minute window from the time scheduled. The DON stated that LVN 3 did not administer the 9 a.m. dose of Mounjaro to Resident 128 on 1/12/2026 because the medication was not available in the facility. The DON stated Mounjaro was prescribed by Resident 128's physician for management of DM 2 and missing a dose can potentially harm Resident 128 by not controlling blood sugar levels by increasing the risk of hypoglycemia or hyperglycemia leading to potential hospitalization. During the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same interview, the DON stated that medication eKITS containing CMs need to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated three (3) eKITS containing CMs in Medication Room 1 refrigerator were not reconciled at every shift in January 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CMs. During a review of Resident 30's admission Record dated 1/12/2026, the admission Record indicated the facility originally admitted Resident 30 to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery (removes damaged bone from a joint to relieve pain and restore function, requiring pain management during recovery) of the knee. During a review of Resident 30's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/21/2025, the MDS indicated Resident 30 had intact cognition and normal memory and thinking. During a review of Resident 30's Order Summary Report (a report listing the physician order for the resident), dated 1/12/2025, the Order Summary Report indicated Resident 30 was prescribed Hydrocodone-acetaminophen 10-325 mg tablet orally every 4 hours as needed for severe pain (7-10), starting 12/18/2025. During a review of Resident 30's Progress note dated 1/12/2026 9:50 a.m. by the DON, the progress note stated the following: During med pass resident asked the 7-3 charge nurse for her pain medication, Norco 10/325mg. Charge nurse checked if she is due and based on MAR she is not due yet as it was documented give at 7:22AM. Per resident this is not accurate as she received it past midnight. Upon checking the Narcotic count sheet, it was logged that the medication was given at 1AM. Upon verification with the 11-7 charge nurse he confirmed what resident stated that she received it at 1 AM. Per charge nurse he made an error in documentation, when he remembered that he did not document on the MAR earlier and documented at the time he did recall to do so and it was already 7:22AM. MD was informed and gave 1 time order to give medication. Resident made aware. During a review of Resident 30's electronic MAR (eMAR) for January 2026, the eMAR indicated LVN 2 documented administration of hydrocodone-acetaminophen 10-325 mg tablet to Resident 30 on 1/12/2026 at 7:22 a.m. During a review of Resident 30's MAR for January 2026, the MAR indicated Resident 30 received a one-time dose of hydrocodone-acetaminophen 10-325 mg on 1/12/2026 at 9:35 a.m. by LVN 3. During a review of Resident 128's admission Record dated 1/12/2026, the admission Record indicated the facility admitted Resident 128 to the facility on 1/6/2026 with diagnoses including DM 2. During a review of Resident 128's Order Summary Report, dated 1/12/2026, the Order Summary Report indicated Resident 126 was prescribed Mounjaro 0.5 ml subcutaneously (under the skin) once a day every Monday for DM2, on 1/6/2026. During a review of Resident 128's MAR for January 2026, the MAR indicated Resident 128 was prescribed Mounjaro 0.5 ml subcutaneously once a day every Monday for DM 2, to be given on 1/12/2026 at 9.a.m. There was no documentation for the administration of Mounjaro 0.5 ml on 1/12/2026 at 9.a.m. During a review of the Policy and Procedures (P&P,) titled Controlled Medication Storage, last reviewed 1/16/2025, the P&P indicated that At each shift change, a physical inventory of all CMs, including the emergency supply is conducted by two licensed nurses and is documented on the CM accountability record. During a review of the P&P titled Controlled Medications, last reviewed 1/16/2025, the P&P indicated: C. When a CM is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) date and time of administration 2) amount administered 4) initials of the nurse administering the dose of the MAR after the medication is administered. During a review of the P&P, titled Ordering and Receiving Medications from the Dispensing Pharmacy, last reviewed 1/16/2025, the P&P indicated that Medications are received from the dispensing pharmacy on a timely basis. 3) New medications are ordered as follows: a. if needed before the next regular delivery, inform pharmacy of the need for prompt delivery. 6) New Admission/re-admission Orders: c. Facility indicates whether a new supply of medication is needed from the pharmacy. During a review of the P&P titled Medication Administration - General Guidelines, last reviewed 1/16/2025, the P&P indicated Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after.)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 28 total opportunities contributed to an overall medication error rate of 10.71% affecting two (2) of three (3) residents observed for medication administration (Resident 2 and 128.) The medication errors were as follows: 1. Resident 2 did not receive ascorbic acid (a supplement used to support and improve the immune system) as ordered by Resident 2's physician. 2. Resident 128 did not receive Mounjaro (a medication used for Diabetes Mellitus 2 [DM2] - a condition of having high blood sugar levels) as ordered by Resident 128's physician and received metformin (a medication used for DM2) at a different time than ordered by Resident 128's physician. These failures had the potential to result in Resident 2 and 128 to experience adverse effects (unwanted, uncomfortable, or dangerous effects) such as uncontrolled blood sugar levels, hypoglycemia (low blood sugar level,) hyperglycemia (high blood sugar level,) and coma and the potential to result in Residents 2's and 128's health and well-being to be negatively impacted. Findings: During an observation on 1/12/2026 at 9:39 a.m., in Medication Cart 2, Licensed Vocational Nurse (LVN) 3 was observed administering aspirin (a medication used for pain, fever or heart health,) cetirizine (medication used for allergies,) vitamin D3 (a supplement used for keeping muscles and brain cells working,) doxycycline (a medication used for infections,) methimazole (a medication used for high thyroid levels,) metformin, montelukast (a medication used for allergies,) oxycodone - acetaminophen (a medication used for pain,) fluticasone (a medication used for allergies), azelastine (a medication used for allergies) and was observed not administering Mounjaro 0.5 milliliter ([ml] - a unit of measure of volume) subcutaneous ([SQ] - under the skin) injection to Resident 128. Resident 128 was observed swallowing the oral medications with a glass of juice. During an interview on 1/12/2026 at 1:25 p.m., with LVN 3, LVN 3 stated that LVN 3 did not administer Mounjaro 0.5 ml SQ injection to Resident 128 at the 9 a.m. scheduled time that day (1/12/2026,) because the medication was not available in the medication cart or in the facility. LVN 3 stated LVN 3 will follow up with the pharmacy to expedite the delivery of Mounjaro and call the physician to inform the morning dose (on 1/12/2026) was not administered. LVN 3 stated, per facility policy, there was a 60-minute window for medication administration and not administering a medication within this window was considered a medication error. LVN 3 stated it was important to administer Mounjaro as ordered by physician for DM2, and skipping or delaying a dose can harm Resident 128 by causing high or low blood sugar levels, leading to coma and requiring hospitalization. During the same interview, LVN 3 stated that LVN 3 administered metformin 1000 milligram ([mg] - a unit of measure of mass) tablet during the morning medication administration at 9:39 a.m. to Resident 128. LVN 3 acknowledged the physician's order specified to administer metformin at 7:30 a.m. with breakfast. LVN 3 stated, per facility policy, there was a 60-minute window for medication administration and LVN 3 administered the metformin later than that timeframe. LVN 3 stated this was considered a medication error. During an observation on 1/12/2026 at 10:08 a.m., in Medication Cart 3, LVN 6 was observed administering vitamin D (a medication used for bone support,) Eliquis (a medication used for preventing blood clots,) docusate (a medication used for softening the stool,) dapagliflozin (a medication used for DM2,) gabapentin (a medication used for nerve pain,) lisinopril (a medication used for high blood pressure,) lubiprostone (a medication used for constipation,) milk of magnesia (a medication used for constipation,) Miralax (a medication used for constipation,) senna (a medication used for constipation,) simethicone (a medication used for constipation,) multivitamins with minerals tablets orally, cyclosporine (a medication used to treat dry eyes) to the eyes, and not administering ascorbic acid to Resident 2. Resident 2 was observed swallowing the oral medications with a full glass of water. During an interview on 1/12/2025 at 1:30 p.m., with LVN 6, LVN 6 stated administered vitamin D, Eliquis, docusate, dapagliflozin, gabapentin, lisinopril, lubiprostone, milk of (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	magnesia, Miralax, senna, simethicone, multivitamins with minerals, and cyclosporine to Resident 2, and failed to prepare and administer ascorbic acid to Resident 2 as prescribed by the physician, during the morning medication administration at 10:08 a.m. LVN 6 stated not administering ascorbic acid was not beneficial for Resident 6 and can harm Resident 6 by not supporting immunity. LVN 6 stated that LVN 6 failed to follow 5 rights (right patient, right medication, right time, right dose, right route) of medication administration, and this was considered a medication error. During an interview on 1/13/2026 1:10 p.m., with the Director of Nursing (DON), the DON stated that per that facility policy medications should be administered within a 60-minute window from the time scheduled. The DON acknowledged that LVN 3 and LVN 6 failed to follow five (5) rights of medication administration and facility medication administration guidelines to ensure physician orders were followed as prescribed and medications administered at the right time to Resident 2 and 128. The DON stated that LVN 3 failed to administer metformin 1000 mg tablet to Resident 128 and LVN 6 failed to administer ascorbic acid tablet to Resident 2, at the scheduled time and according to physician orders. The DON stated these were considered medication errors. The DON stated that not administering the correct medications can lead to harm by causing more adverse effects to residents and does not treat their condition. The DON stated Resident 2 may not benefit from immune support without ascorbic acid, and that Resident 128 may be at risk for developing stomach irritation from receiving metformin at 9:39 a.m. without a meal. During the same interview, the DON stated that medications should be readily available for administration at the scheduled times and as ordered by the physician. The DON stated that LVN 3 did not administer the 9 a.m. dose of Mounjaro to Resident 128 on 1/12/2026 because the medication was not available in the facility. The DON stated Mounjaro was prescribed by Resident 128's physician for management of DM2 and missing a dose can potentially harm Resident 128 by not controlling blood sugar levels by increasing the risk of hypoglycemia or hyperglycemia leading to potential hospitalization. The DON stated this was also considered a medication error. During a review of Resident 2's admission Record (a document containing demographic and diagnostic information,) dated 1/12/2026, the record indicated the facility originally admitted Resident 2 to the facility on 1/11/2023 and re-admitted on [DATE] with diagnoses including DM2 and immune deficiency (a condition where the immune system is weakened). During a review of Resident 2's Order Summary Report, dated 1/28/2025, the Order Summary Report indicated Resident 2 was prescribed ascorbic acid 500 mg one (1) tablet orally once a day for supplement, starting 12/28/2025. During a review of Resident 2's Medication Administration Record ([MAR] - a record of medications administered to residents), for January 2026, the MAR indicated Resident 2 was prescribed ascorbic acid 500 mg to give one (1) tablet orally once a day for supplement, at 9 a.m. During a review of Resident 128's admission Record dated 1/12/2026, the admission Record indicated the facility originally admitted Resident 128 to the facility on 1/6/2026 with diagnoses including DM2. During a review of Resident 128's Order Summary Report, dated 1/12/2026, the Order Summary Report indicated Resident 128 was prescribed: 1. Mounjaro 0.5 ml SQ once a day every Monday for DM2, on 1/6/2026. 2. Metformin 1000 mg one (1) tablet orally twice a day with breakfast and dinner, starting 1/7/2026. During a review of Resident 128's MAR for January 2026, the MAR indicated Resident 128 was prescribed: 1. Mounjaro 0.5 ml SQ once a day every Monday for DM2, to be given on 1/12/2026 at 9 a.m. 2. Metformin 1000 mg to give one (1) tablet orally twice a day with breakfast and dinner, at 7:30 a.m. and 5:30 p.m. During a review of the facility's policy and procedures (P&P), titled Medication Administration - General Guidelines, last reviewed 1/16/2025, the P&P indicated Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after.) During a review of the facility's P&P, titled Medication Errors, last reviewed 1/16/2025, the P&P indicated: b. Medication Error means the administration of medication: At the wrong time. During a review of the facility's provided document, titled Meals Times, [undated], the document indicated: Breakfast - 7:30 a.m. to 8:30 a.m Meals may be served the 15 minutes before or after scheduled time.		

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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, and record review the facility failed to store medications in accordance with manufacturer specifications, professional standards of practice and facility policy and procedures by failing to: 1.Label one (1) inhalation solution with a date indicating when use began for Resident 46, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medication carts (Medication Cart 5.) 2. Label, remove from use and discard two (2) discontinued medications for Resident 54 and 62, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medication carts (Medication Cart 4.) 3. Remove from use and discard one (1) expired medication from facility stock, and one (1) expired and discontinued medication for Resident 88, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medication rooms (Medication room [ROOM NUMBER].) 4. Ensure eye drops were stored separately from orally administered medications, in two (2) of two (2) inspected medication rooms (Medication room [ROOM NUMBER] and 2.) These deficient practices increased the risk for Residents 46, 54, 62, 88, and other residents to receive medication that had become ineffective or toxic due to improper storage or labeling and increase the risk of infections and receiving medications via the wrong route (internal versus external routes,) possibly leading to adverse health consequences resulting in hospitalization or death. Findings: During an observation on 1/13/2026 at 9:15 am, in Medication room [ROOM NUMBER], in the presence of Registered Nurse (RN) 1, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, expired and not discarded, or stored contrary to facility policies: 1.An opened box of acetaminophen (medication used to treat pain or fever) suppositories (form of medication used for rectal administration) for facility stock containing five (5) acetaminophen suppositories was found stored at room temperature in the cabinet with other unexpired facility stock medications and labeled with an expiration date of 8/2025. According to the manufacturer date imprinted on the acetaminophen box, the medication should be used or discarded by August 2025. 2. One (1) Daptomycin (an antibiotic - a medicine that fights infections by killing bacteria or stopping them from growing) intravenous (to be administered through the vein) bag for Resident 88 stored in the refrigerator with an expiration date of 1/13/2026 and not marked for discontinuation or separated from the remaining medications in use. During a review of Resident 88's clinical chart, the chart indicated Resident 88 was discharged on 1/5/2026 from the facility. During a concurrent interview, RN 1 acknowledged five (5) acetaminophen suppositories for facility stock expired August of 2025 and Daptomycin bag for Resident 88 expired on 1/13/2026. RN 1 stated expired medications should be removed from use and placed in the expired medication bin to be disposed of and prevent accidental use. RN1 stated the acetaminophen suppositories needed to be removed from use before August 2025, and Resident 88's Daptomycin bag needed to be removed from the refrigerator when Resident 88 was discharged from the facility on 1/5/2026, and certainly prior to the 1/13/2026 expiration date. RN 1 stated expired medications have lost potency (strength) and will not be effective when used in error for residents in the facility. RN 1 stating using expired acetaminophen will not be effective in lowering the resident's temperature or relieving the pain, and using expired Daptomycin will not be effective in treating Resident 88's infection. RN 1 stated the facility failed to remove expired medications and medications for discharged residents from use and placed in a designated area for disposal. During an observation on 1/13/2026 at 11:35 am, in Medication Cart 4, in the presence of Licensed Vocational Nurse (LVN) 1, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, discontinued (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and not discarded, or stored and labeled contrary to facility policies: 1. One (1) open budesonide (a respiratory medication used for asthma [a condition that causes shortness of breath]) inhalation solution foil envelope containing 4 unused vials/ampules for Resident 54 was found stored at room temperature without a date indicating when the foil envelope was opened. The remaining budesonide envelopes were not marked for discontinuation or separated from the remaining medications in use. According to manufacturer guidelines, once the budesonide foil envelope was opened, the shelf life for unused vials was 2 weeks. During a review of Resident 54's Respiratory Treatment Medication Administration Record for November 2025, the record indicated budesonide was discontinued on 11/30/2025. 2. One (1) open and used albuterol (a respiratory medication used to prevent and treat difficulty in breathing, shortness of breath, and coughing) inhaler for Resident 62 was found stored at room temperature and not marked for discontinuation or separated from the remaining medications in use. During a review of Resident 62's clinical chart, the chart indicated Resident 62 was discharged on 1/6/2026 from the facility. 3. One (1) brimonidine (a medication used to lower high blood pressure in the eye) eye drop solution stored with nitroglycerin (a medication used to treat chest pain) oral tablets, and Glyco Sync (a supplement used for blood sugar balance) oral capsules in the same bin of the medication cart. During a concurrent interview with LVN 1, LVN 1 stated the budesonide inhalation foil envelope for Resident 54 was not labeled with a date when the foil envelope was opened and used. LVN 1 stated according to facility policy multi-use medications like respiratory inhalation solutions should be labeled with the date when first opened to know when they expire and need to be discarded, and that according to the manufacturer guidelines once the budesonide foil envelope was opened the remaining vials needed to be used or discarded within two (2) weeks. LVN 1 added that budesonide for Resident 54 was discontinued in November 2025 and according to facility policy discontinued medications need to be immediately removed from use to prevent accidental use and placed in a designated area for disposal. LVN 1 also stated that Resident 62 was discharged from the facility on 1/6/2026. LVN 1 stated that the albuterol for Resident 62 needed to be removed from the medication cart and placed in a designated area when Resident 62 was discharged from the facility on 1/6/2026. LVN 1 stated the facility failed to remove medications for discharged residents and discontinued medications from use, and label multi use inhalations with a date indicating when first use began. During the same interview LVN 1 stated that orally administered medications and eye drops should be stored separately in their own sections/bins, not together, to prevent errors in wrong route administration and possible infections. LVN 1 stated the facility failed not to separate and store brimonidine eye drop solution from nitroglycerin oral tablets, and Glyco Sync oral capsules. During an observation on 1/13/2026 at 12:25 am, in Medication Cart 2, in the presence of LVN 3, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open Spiriva (a respiratory medication used for chronic obstructive pulmonary disease [COPD - a condition that causes shortness of breath]) inhaler for Resident 46 was found stored at room temperature without a date indicating when the inhaler was first opened. According to manufacturer guidelines, the Spiriva inhaler should be discarded at the latest three (3) months after first use or when the locking mechanism is engaged, whichever comes first. 2. Four (4) different eye drop solutions stored with cranberry oral tablets in the same bin of the medication cart. 3. One (1) Visine (a medication used for dry eyes) eye drop solution stored with throat lozenges and calcium tablets, in the same bin of the medication cart. 4. One (1) refresh tears (a medication used for dry eyes) eye drop solution stored with naratriptan (a medication used for headaches) oral tablets in the same bin of the medication cart. During a concurrent interview LVN 3 stated the Spiriva inhaler for Resident 46 was opened and not labeled with a date when it was first used. LVN 3 stated according to facility policy multi-use medications like respiratory inhalation solutions should be labeled with the date when first opened to know when they expire and need to be discarded, and that according to the manufacturer guidelines once the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Spiriva was opened the solution needed to be used or discarded within three (3) months. LVN 3 stated the facility failed to label multi use inhalations with a date indicating when use first began. During the same interview LVN 3 stated that orally administered medications and eye drops should be stored separately in their own sections/bins, not together, to prevent errors in wrong route administration and possible infections. LVN 3 acknowledged three (3) separate bins in the medication cart contained a mix of oral medications and eye drops. LVN 3 stated the facility failed not to separate and store eye drop solutions from oral medications. During an interview on 1/13/2026 at 1:10 p.m., with Director of Nursing (DON,) the DON stated per facility policy, multi-dose medications, such as inhalation solutions and inhalers, need to be labeled with the date when opened to know when they expire and need to be discarded. The DON stated several LVN's failed to label Spiriva for Resident 46 the inhalation solutions with the date when opened. During the same interview, the DON stated that when residents are discharged from the facility or medications are discontinued, the resident's medications should be immediately removed from medication carts and/or refrigerators and placed in a designated area indicated for disposal. The DON stated several LVN's failed to remove discontinued medications from use for Resident 54, 62 and 88, increasing the risk of accidental use. During the same interview, the DON stated that expired medications are ineffective and may not work properly and need to be removed from use. The DON stated that several LVN's failed to remove expired acetaminophen suppositories from facility stock and Daptomycin for Resident 88, increasing the potential for use of expired medications and harming residents by not treating their condition, such as high fevers and infections. During the same interview the DON stated internally (such as oral, intravenous) and externally (such as eyes, ears, nose, skin) administered medications should be stored separately to prevent wrong route administration, infections and contaminations. The DON stated the facility failed to store eye drops in Medication Cart Windsor and Kensington 2 separate from oral medications. During a review of facility's Policy and Procedures (P&P) titled, Storage of Medications, last reviewed on 1/16/2025, the P&P indicated that Medications and biologicals are stored safely, and properly, following manufacturer's recommendations or those of the supplier. C. Orally administered medications are kept separate from externally used medications. M. Outdated, contaminated, or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of facility's P&P titled, Discontinued Medications, last reviewed on 1/16/2025, the P&P indicated that When medication are expired, discontinued by a prescriber, the resident is transferred or discharged .the medications are marked as discontinued or stored in a separate location and later destroyed. If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue. During a review of facility's P&P titled, Procedures for All Medications, last reviewed on 1/16/2025, the P&P indicated that When opening a multi-dose container, place the date on the container. During a review of manufacturer's guide Highlights of Prescribing Information for budesonide inhalation dated 11/2018, the guide indicated Budesonide inhalation suspension should be stored upright at controlled room temperature 68 to 77 degrees Fahrenheit and protected from light. When an envelope has been opened, the shelf life of the unused ampules is 2 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. Any opened ampule must be used promptly. During a review of manufacturer's guide Highlights of Prescribing Information for Spiriva dated 9/2015, the guide indicated inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the dietary menu when the facility failed to include condiments with a meal that required the items for six (Resident 32, Resident 43, Resident 56, Resident 58, Resident 64, and Resident 67) of 73 residents prescribed a regular diet. This had the potential for the food to not be attractive in appearance and taste and increase the risk of a resident not eating the meal. Findings: a. During a review of Resident 32's admission Record (or Facesheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident to the facility on 2/6/2023 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 32 s Minimum Data Set (MDS, a resident assessment tool), dated 12/03/2025, the MDS indicated Resident 32 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 32 required setup or clean-up assistance (helper sets up or cleans up; resident completes the activity) with eating. During a review of Resident 32's Physician's Orders, dated 8/19/2025, the orders indicated Resident 32 was prescribed a regular, no added salt, regular texture, thin consistency (a regular diet with no modifications to food or liquid texture). During a review of Resident 32's Care Plan for Nutrition, initiated 6/03/2025, the care plan indicated a goal that the resident will not develop complications related to obesity. The care plan indicated an intervention to provide and serve diet as ordered. b. During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 43 required setup or clean-up assistance with eating. During a review of Resident 43's Physician's Orders, dated 10/16/2025, the orders indicated Resident 43 was prescribed a carbohydrate controlled (diet low in carbohydrates [sugar, starch fiber]), no added salt, regular texture, thin consistency. During a review of Resident 43's Care Plan for Nutrition, initiated 5/02/2025, the care plan indicated a goal that the resident will not develop complications related to obesity. The care plan indicated an intervention to provide and serve diet as ordered. During a review of Resident 43's diet ticket (slip of paper that indicates the specific meal being served to a resident based on their dietary restriction and preference, is placed by the enclosed plate on a tray) for 1/11/2026, the diet ticket indicated Resident 43 was to receive, but not limited to, hamburger and 3 teaspoons of ketchup, mayonnaise, and mustard. c. During a review of Resident 56's admission Record, the admission Record indicated the facility admitted the resident to the facility on 4/05/2023 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a stroke (a lack of oxygen to the brain). During a review of Resident 56's MDS, dated [DATE], the document indicated Resident 56 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 56 required setup or clean-up assistance with eating. During a review of Resident 56's Physician's Orders, dated 9/23/2025, the orders indicated Resident 56 was prescribed a regular diet, regular texture, thin consistency, small portion. During a review of Resident 56's Care Plan for Nutrition, initiated 4/12/2023, the care plan indicated a goal that the resident will maintain adequate nutritional status as evidenced by maintaining weight within a positive or negative 5% of current body weight, no signs or symptoms of malnutrition, and consuming at least 50-75% of at least two meals daily through the review date. The care plan indicated an intervention to provide and serve diet as ordered. During a review of Resident 56's diet ticket for 1/11/2026, the diet ticket indicated Resident (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	56 was to receive, but not limited to, hamburger and 3 teaspoons of ketchup, mayonnaise, and mustard. d. During a review of Resident 58's admission Record, the admission Record indicated the facility admitted the resident to the facility on 6/24/2014 and re-admitted on [DATE] with diagnoses that included COPD. During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 58 was independent with eating. During a review of Resident 58's Physician's Orders, dated 3/11/2025, the orders indicated Resident 58 was prescribed a carbohydrate controlled (diet low in carbohydrates [sugar, starch fiber]), no added salt, regular texture, thin consistency. During a review of Resident 58's Care Plan for Nutrition, initiated 6/16/2025, the care plan indicated a goal that the resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% of current body weight, and consuming at least 50-75% of at least two meals daily through the review date. During a review of Resident 58's diet ticket for 1/11/2026, the diet ticket indicated Resident 58 was to receive, but not limited to, hamburger and 3 teaspoons of ketchup, mayonnaise, and mustard. e. During a review of Resident 64's admission Record, the admission Record indicated the facility resident to the facility on 7/28/2023 and re-admitted on [DATE] with diagnoses that included hypertension (high blood pressure). During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 64 was independent with eating. During a review of Resident 64's Physician's Orders, dated 10/22/2024, the orders indicated Resident 64 was prescribed a regular diet Regular diet Regular texture, thin consistency. During a review of Resident 64's Care Plan for Nutrition, initiated 3/26/2024, the care plan indicated a goal that the resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% of current body weight, and consuming at least 50-75% of at least two meals daily through the review date. The care plan indicated an intervention to provide and serve diet as ordered. During a review of Resident 64's diet ticket for 1/11/2026, the diet ticket indicated Resident 64 was to receive, but not limited to, hamburger and 3 teaspoons of ketchup, mayonnaise, and mustard. f. During a review of Resident 67's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included COPD. During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 64 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 67 needed supervision with eating. During a review of Resident 67's Physician's Orders, dated 11/03/2025, the orders indicated Resident 67 was prescribed a regular diet, easy to chew texture (for people who can chew soft, tender foods but need them to break apart easily with minimal effort), thin consistency liquids. During a review of Resident 67's Care Plan for Nutrition, initiated 8/20/2024, the care plan indicated a goal that the resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% of current body weight, and consuming at least 50-75% of at least two meals daily through the review date. The care plan indicated an intervention to provide and serve diet as ordered. During a review of the Weekly Dietary Menu, the menu indicated the Sunday evening meal the residents were to receive hamburger, tater tots, lettuce, tomato, pickle, banana mandarin oranges, Milk 2%, and ketchup, mayonnaise, and mustard. During the Resident Council meeting (a meeting in which the survey team meets with residents as a group and asks them questions regarding their care in the facility) on 1/12/2026 at 2:30 p.m., Resident 43, Resident 56, and Resident 58 stated they did not receive any condiments with their hamburger they received at dinner on 1/11/2026. Resident 67 stated she only received a small hamburger with no condiments at dinner on 1/11/2026. During an interview with Resident 56 and Resident 32 on 1/13/2026 at 9:25 a.m., they both stated they did not receive condiments with their hamburger at dinner on 1/11/2026. Resident 56 and 32 stated their certified nursing assistant (did not specify) told them the kitchen does not have any condiments. During a concurrent interview and record review with the Dietary District Manager (DDM) on 1/13/2026 at 9:51 a.m., the DDM reviewed the Dietary Menu. The DDM stated he was not present in the facility for the evening meal of 1/11/2026 but the condiments: ketchup, mayonnaise, and mustard (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were to be served with the hamburger for the 1/11/2026 evening meal. The DDM stated it is important to have a condiment on the individual trays because if they are on the menu that is what the residents will expect. During an interview with Certified Nursing Assistant 6 (CNA 6) on 1/13/2026 at 3:58 p.m., she stated the residents had a burger and tater tots on their trays but did not have mustard or ketchup. CNA 6 stated she was unsure about the mayonnaise because she assumed it would be on the bun with the meat and she did not lift the bun to see if there was mayonnaise. CNA 6 stated the residents were mad. CNA 6 stated she went to the kitchen and received ketchup for her residents but was told the kitchen was out of mustard. During an interview with Resident 43 on 1/14/2026 at 1:20 p.m., he stated that he did not receive condiments or lettuce or tomatoes with his hamburger on 1/11/2026 for the dinner meal. During an interview with Resident 64 on 1/15/2026 at 10:30 a.m., he stated he did not receive any condiments with his hamburger at dinner on 1/11/2026. During an interview with the Director of Nursing (DON) on 1/15/2026 at 8:17 a.m., she stated the residents should receive condiments if the condiments were listed on the dietary menu. The DON stated this is important because condiments help improve the taste of food, which encourages the resident to eat their meals. The DON stated the residents will expect to get the condiments if they are listed on the dietary ticket. During a review of the facility's policy and procedure (P&P) titled, Menus, last reviewed 1/16/2025, the P&P indicated the menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for two of two sampled residents (Resident 46 and 3) by failing to accurately document the insulin (hormone that regulates the amount of glucose [sugar] in the blood) administration injection site and blood sugar test (measures the glucose levels in your blood) result. This deficient practice placed the resident at risk of not receiving appropriate care due to inaccurate resident medical care information and the potential to result in confusion in the care and services for Resident 46 and 3. Findings: a. During a review of Resident 46's admission Record, the admission Record indicated the facility admitted the resident on 12/28/2025 with diagnoses including muscle weakness, chronic obstructive pulmonary disease (COPD-a lung disease that block airflow and make it difficult to breathe) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 46's History and Physical (H&P) dated 12/30/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 46's Order Summary Report as of 1/15/2026, the Order Summary Report indicated an order for insulin lispro injection solution 100 unit/milliliter (U/ml- unit of measurement), inject per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges), notify physician if blood sugar is less than 70 milligram per deciliter (mg/dl- unit of measurement) or greater than 400 mg/dl subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) before meals and at bedtime for diabetes mellitus, rotate injection site. During a concurrent interview and record review on 1/14/2026 at 2:44 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 46's MAR for 1/2026. Resident 46's MAR indicated that the licensed nurses documented the amount of insulin given but the site of insulin administration was documented as Not Applicable (NA) on the following dates and time: - 1/3/2026 at 11:30 a.m., four (4) units of insulin given and site documented as NA. - 1/5/2026 at 11:30 a.m., five (5) units of insulin given and site documented as NA. - 1/9/2026 at 6:30 a.m., one (1) unit of insulin given and site documented as NA. - 1/9/2026 at 9:00 p.m., 5 units of insulin given and site documented as NA. - 1/10/2026 at 11:30 a.m., 5 units of insulin given and site documented as NA. The ADON stated the nurse administering the insulin should have indicated the injection site used to make sure the next nurse will know where to administer the next dose and stated per policy, the injection site must be rotated. The ADON stated that if no site is indicated there is a chance the same site is used multiple times which can cause tissue scarring, bruising and it may potentially be painful for the resident. The ADON stated they should never document NA for the injection site as this may confuse the nurses if the resident has indeed received a dose of insulin. The ADON stated that correct documentation of the provision of care is essential as these documentations serve as a communication tool for continuity of care. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration Purpose, last reviewed on 1/16/2025, the P&P indicated, Insulin injection sites are routinely rotated, and documentation of blood glucose result as ordered. During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 1/16/2025, the P&P indicated, Services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record shall facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. b. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident on 7/18/2025 and readmitted the resident on 10/1/2025 with diagnoses including muscle weakness, hypertension (high blood pressure [the force of the blood pushing on the blood vessel (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walls is too high)) and type 2 diabetes mellitus. During a review of Resident 3's History and Physical dated 10/3/2025, the H&P indicated that the resident has fluctuating capacity to understand and make decisions. During a review of Resident 3's Order Summary Report as of 1/15/2026, the Order Summary Report indicated an order for insulin aspart injection solution 100 Unit/milliliter, inject per sliding scale, if blood is greater than 349 milligram per deciliter (mg/dl) equals 10 units and notify provider, subcutaneously before meals and at bedtime for diabetes mellitus, rotate injection site. During a concurrent interview and record review on 1/14/2026 at 3:29 p.m., with the ADON, reviewed Resident 3's MAR for 12/2025. Resident 3's MAR indicated that the licensed nurses documented the blood sugar test result as Not Applicable (NA) on the following dates and time: 12/4/2025 at 4:30 p.m., blood sugar test result was documented as NA. 12/4/2025 at 9:00 p.m., blood sugar test result was documented as NA. 12/9/2025-12/13/2025 at 4:30 p.m., blood sugar test result was documented as NA. 12/9/2025-12/13/2025 at 9:00 p.m., blood sugar test result was documented as NA. 12/17/2025-12/19/2025 at 4:30 p.m., blood sugar test result was documented as NA. 12/17/2025-12/19/2025 at 9:00 p.m., blood sugar test result was documented as NA. 12/23/2025-12/27/2025 at 4:30 p.m., blood sugar test result was documented as NA. 12/23/2025-12/27/2025 at 9:00 p.m., blood sugar test result was documented as NA. The ADON stated that it is important to document the blood sugar test results even if they're within the normal range. The ADON stated that documenting consistently the blood sugar test result is part of the diabetic management to ensure that the provider can have a clear picture of the resident's status as far as the insulin therapy is concerned. With this information of the blood sugar test result, the provider can then decide to either discontinue or modify or adjust the insulin dose. ADON stated that the standard of practice is to document everything that's happening to the residents including the assessment of the blood sugar as per order. The ADON stated that incorrect or lack of documentation as far as the resident's progress or decline will affect the management of the resident's diabetes which could lead to resident not attaining his/her treatment goals. During a review of the facility's P&P titled, Insulin Administration Purpose, last reviewed on 1/16/2025, the P&P indicated, Insulin injection sites are routinely rotated, and documentation of blood glucose result as ordered. During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 1/16/2025, the P&P indicated, Services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record shall facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's P&P titled, Obtaining a Fingertstick Glucose Level, last reviewed on 1/16/2025, the P&P indicated, The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. the person performing this procedure should record the following information in the resident's medical record; the blood sugar results.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify the physician of a resident's change of condition for one of one sampled resident (Resident 4) by failing to notify the physician when Resident 4 had signs and symptoms of bleeding and hypoglycemia (low blood sugar in the body). This deficient practice had the potential to result in a delay of care services resulting in serious health complications requiring hospitalization. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 to the facility on 8/30/2023, and re-admitted the resident on 11/24/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) infection. During review of Resident 4's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/1/2025, the MDS indicated Resident 4 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).The MDS indicated Resident 4 has a GT. During a review of Resident 4's Order Summary Report, the Order Summary Report indicated the following orders dated 7/3/2025: -Eliquis (a blood thinner medication) 2.5 milligram (mg-unit of mass), give one tablet via GT two times a day. -Eliquis use: Monitor for signs and symptoms of bleeding (abnormal or unexpected bruising, petechiae [tiny pinpoint sized red, purple or brown on the skin or mucous membrane], internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by documenting (+) yes or (-) no and notify the physician if (+) every shift. -Monitor signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait (ambulation). Document (+) yes or (-) no and notify the MD if (+) every shift. During a concurrent interview and record review with the Director of Nursing (DON) on 1/15/2026 at 10:02 a.m., Resident 4's Medication Administration Record (MAR-a report detailing the medications administered to a resident by the licensed nurse in the facility), progress notes, and Situation, Background, Assessment, Recommendation (SBAR - a structured communication tool used primarily in healthcare to provide concise, clear, and essential information about a resident's condition)/Change in Condition (COC) were reviewed. The MAR indicated a (+) yes for signs and symptoms of bleeding and hypoglycemia on 1/10/2026 during the 11:00 p.m. to 7:00 a.m. shift. Resident 4's progress notes and SBAR/COC (situation, background, appearance and review/Change of condition- structured tool for healthcare provider that provides communication record and used as documentation for any changes of condition) did not indicate documentation of Resident 4 having symptoms of bleeding or hypoglycemia, nor did they (progress notes or SBAR/COC) indicate that the physician was notified of the changes in Resident 4's condition. The DON stated that licensed nurses must follow physician orders and notify the physician of any signs and symptoms of bleeding or hypoglycemia in order to provide proper care to Resident 4. During a review a review of facility's policy and procedure (P&P) titled, Change in Condition: Notification of, reviewed on 1/16/2025, the P&P indicated, Facility will ensure residents, family, legal representatives and physicians are informed of changes in resident's condition. During a review of facility's P&P, titled, Anticoagulation-Clinical Protocol, reviewed on 1/16/2025, the P&P indicated, The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems . if an individual on anticoagulation therapy shows signs and symptoms of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. During a review of facility's P&P, titled, Management of Hypoglycemia, reviewed on 1/16/2025, the P&P indicated, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility will notify the provider immediately and document provider instructions for symptoms of hypoglycemia.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to: 1. Update a resident's comprehensive care plan (a document that summarizes a resident's needs, goals, and care/treatment) for one of one sampled resident (Resident 4) reviewed under the tube feeding care area by failing to update Resident 4's care plan with the most recent physician's order for enteral feeding (a way of delivering nutrition directly to the stomach or small intestine) This deficient practice had the potential to result in failure to deliver the necessary care and services to meet Resident 4's nutritional needs related to tube feeding. 2. Ensure the resident or the resident's representative participated during the Interdisciplinary (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) care plan meeting for one of five sampled resident (Resident 7) reviewed under the care planning care area. This deficient practice had the potential to result in Resident 7 not receiving person centered care (person-centered care allows patients to make informed decisions about their treatment and well-being) to meet the resident's needs. Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 to the facility on 8/30/2023 and re-admitted the resident on 11/24/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) infection. During review of Resident 4's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/1/2025, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and was dependent on staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 4 had a GT. During a review of Resident 4's Order Summary Report, the Order Summary Report indicated an order dated 1/9/2026 to administer Glucerna (type of enteral feeding) 1.2 calories at 55 cubic centimeters (cc-unit of volume) to make 1100 millimeters (ml-unit of volume) per day via pump with 100 ml of water flush every four hours. During a concurrent interview and record review with the Director of Nursing (DON) on 1/15/2026 at 10:02 a.m., Resident 4's care plan (CP) for enteral feeding created on 9/6/2023 and Order Summary Report were reviewed. The CP indicated that Resident 4 required enteral feeding and must maintain nutritional status via tube feeding. The CP indicated that Resident 4 had an order to provide the resident with Isosource (type of enteral feeding) 1.5 at 50 ml per hour (ml/hour) for 20 hours. The DON stated that the care plan was not updated to reflect the resident's current enteral feeding order. The DON stated it is important to update Resident 4's care plan to ensure staff are aware of how to properly care for the resident. During a review a review of facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, reviewed on 1/16/2025, the P&P indicated, A comprehensive, person-centered care plan includes measurable objectives, and timetables to meet (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's physical, psychosocial and functional needs will be developed and implemented for each resident. P&P also indicated that Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 2. During a review of Resident 7's admission Record, the admission Record indicated the facility originally admitted the resident on 9/05/2021 and readmitted the resident on 1/18/2025 with diagnoses including muscle weakness and dementia (severe memory, thinking, and reasoning decline that interferes with daily life, caused by diseases damaging brain cells). During a review of Resident 7's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/24/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision was moderately impaired and was totally dependent on staff for activities of daily living (these activities include personal care tasks such as eating, dressing, bathing, toileting, managing continence, and transferring). During an interview and record review on 01/15/2026 at 9:31 a.m., with the Minimum Data Set Nurse (MDSN), Resident 7's IDT Care Conferences from 01/2025 to 12/2025 were reviewed. The MDSN stated that the facility did not conduct the IDT care conference for Resident 7 for two quarters, on 5/2025 and 11/2025. The MDSN stated that the IDT Care Conference is conducted quarterly in conjunction with the required quarterly MDS assessment. The MDSN stated that one of the purposes of the IDT Care Conference is to evaluate all areas of care and determine whether the resident had made progress toward care plan goals or experienced a decline, in which case the care plan objectives and interventions would be modified. The MDSN stated that they are required to conduct the IDT Conference quarterly and it is important to involve the resident and their representative in the care planning process so their input and concerns can be addressed. The MDSN further stated that Resident 7 and their representative have the right to participate in care planning to ensure the resident receives the necessary care and services to meet their needs goals. During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning last reviewed 1/16/2025, the P&P indicated that the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops, and implements a comprehensive, person-centered care plan for each resident. the interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility's P&P titled Care Planning-Interdisciplinary Team, last reviewed 1/16/2025, the P&P indicated that Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. the resident, the resident's representative are encouraged to participate in the development of and revisions to the resident's care plan.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 93) received treatment and care in accordance with professional standards of practice by failing to: 1. Ensure licensed nurses clarify the order for digoxin with the physician and obtain an order to monitor the apical pulse (a pulse point on your chest that gives the most accurate heart rate) or set apical pulse parameters (a specific, pre-set guideline for when to temporarily stop a medication, such as a blood pressure drug, to prevent a patient's blood pressure or heart rate from falling too low) before administering digoxin (medication that slows the heart rate). 2. Ensure licensed nurses clarify the order for metoprolol (BP and heart rate lowering medication) and diltiazem (blood pressure [BP] medication that could lower the heart rate) and obtain physician-ordered heart rate parameters prior to administering both medications. This deficient practice had the potential cause hypotension (when the blood pressure [BP] is too low), fainting, falling and/or accidents for Resident 93. Findings: During a review of Resident 93's admission Record, the admission Record indicated the facility admitted Resident 93 on 12/24/2025 with diagnoses that included congestive heart failure (CHF - when the heart muscle cannot pump enough blood to meet the body's needs), atrial fibrillation (A-fib - an irregular and often very rapid heart rhythm) and hypertension (high BP) During a review of Resident 93's History and Physical (H&P), dated 12/26/2025, the H&P indicated Resident 93 did not have the capacity to understand and make decisions. During a review of Resident 93's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/27/2025, the MDS indicated Resident 93 rarely understood others and rarely was able to make herself understood. The MDS indicated Resident 93 was completely dependent on staff for activities such as toileting, dressing, and putting on/taking off footwear. During a review of Resident 93's Order Summary Report, the Order Summary Report indicated the following orders dated 12/24/2025: -Digoxin oral tablet 125 micrograms (mcg- a unit of mass) via percutaneous endoscopic gastrostomy (PEG, a flexible feeding tube placed through the abdominal wall directly into the stomach using an endoscope [a medical device with a light attached, used to look inside a body cavity or organ] tube one time a day for A-fib. -Diltiazem Tablet 60 milligrams (mg-a unit of mass). Give 0.5 mg tablet via PEG-tube four times a day for hypertension. Hold for SBP (systolic blood pressure - the first/top number in a blood pressure reading) <110 (less than 110). -Metoprolol Tablet 25 mg. Give 0.5 mg tablet via PEG-tube every 12 hours for hypertension. Hold for SBP <110. During a review of Resident 93's electronic medication administration record (emar) from 12/24/2025 to 1/14/2026, the EMAR did not have a supplemental section under digoxin to record an apical pulse, nor did it have a supplemental section under diltiazem and metoprolol to record the heart rate. During a concurrent interview and record review on 1/15/2026 at 11:38 a.m. of Resident 93's EMAR dated 12/24/2025 to 1/14/2026 with Registered Nurse 1 (RN 1), RN 1 reviewed the administration of digoxin, diltiazem and metoprolol and stated that these three medications are missing the heart rate parameters and a supplemental section to record the apical pulse for digoxin and heart rate for diltiazem and metoprolol. RN 1 stated that when a telephone order is received, it must be read back or clarified with the physician to ensure resident safety. RN 1 stated when transcribing any medication with parameters or special instructions, the nurse must add a supplemental documentation section in order to record things such as BP, heart rate etc. RN 1 stated digoxin is an especially strong medication and Resident 93 could have experienced bradycardia (slow heart rate), dizziness and fainting. During an interview on 1/15/2026 at 1:25 p.m. with the Director of Nursing (DON), the DON stated licensed staff must clarify with the physician and read back if it is a telephone order to ensure accuracy. The DON stated it is considered a medication error to give digoxin, diltiazem and metoprolol without checking the heart rate first, because it could result in bradycardia which could cause Resident 93 to experience dizziness and fainting During a review of the facility's policy and procedure (P&P), titled, Medication Administration - General Guidelines, last reviewed on 1/16/2026, the P&P indicated medications are administered as (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed in accordance with good nursing principles and practices.if the dose seems excessive etc., contact prescriber for clarification. During a review of the facility provided manufacturer's guideline on the use of digoxin, undated, the guideline indicated digoxin could cause severe bradycardia. The guideline further instructs patients to check and record their heart rate daily. During a review of the facility provided manufacturer's guideline on the use of diltiazem, undated, the guideline indicated a potential adverse effect (an unwanted, harmful, or unfavorable outcome that occurs from a medical treatment, drug, or procedure) was bradycardia (slow heart rate) During a review of the facility provided manufacturer's guideline on the use of metoprolol (a beta blocker [group of medication that lowers BP and heartrate] medication, undated, the guideline indicated a potential adverse of bradycardia and further indicated if both digoxin and a beta blocker is taken together, there is an even higher risk for bradycardia.		

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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. Based on observation, interview and record review, the facility failed to offer sufficient fluid intake to maintain proper hydration (the process of replacing water in the body) and health by failing to provide a pitcher of water and a cup at the bedside of one of three sampled residents (Resident 20) investigated under the hydration care area. This deficient practice placed Resident 20 at an increased risk for dehydration (a condition caused by the loss of too much fluid from the body). Findings: During a review of Resident 20's admission Record, the admission Record indicated the facility initially admitted Resident 20 on 6/3/2014 and readmitted her on 4/21/2023 with diagnoses that included peptic ulcer (an open sore or painful wound that develops on the lining of your stomach/digestive tract), dysphagia (difficulty swallowing) and gastro-esophageal reflux disease (long term condition when stomach acid frequently flows back up into the esophagus [food pipe], causing irritation. During a review of Resident 20's History and Physical (H&P), dated 10/27/2025, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/15/2025, the MDS indicated Resident 20 sometimes understood others and sometimes made herself understood and required assistance from facility staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 20's Care Plan (CP) dated 12/21/2025, the CP indicated Resident 20 was at high risk for dehydration with interventions to encourage Resident 20 to drink the fluids of her choice and ensure Resident 20 has access to liquids whenever possible. During a review of Resident 20's Physician's Order, the Physician's Order indicated an order dated 9/16/2025 for regular diet, soft and bite sized texture, thin consistency (liquids). During an observation on 1/12/2026 at 9:22 a.m. in Resident 20's room, Resident 20 was lying in bed asleep. Resident 20 did not have a water pitcher at her bedside. During a concurrent observation and interview on 1/12/2026 at 9:29 a.m. in Resident 20's room with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated Resident 20 did not have a water pitcher at bedside but should have one to help prevent dehydration. CNA 3 stated the dietary staff changes the water pitchers daily around 11:00 a.m. During an interview on 1/15/2026 at 10:03 m with Registered Nurse 1 (RN 1), RN 1 stated proper hydration is extremely important for all residents. RN 1 stated staff encourage hydration by providing individual water pitchers at the resident's bedside in accordance with the prescribed diet. RN 1 stated Resident 20 should have had a water pitcher at her bedside readily available to prevent dehydration. During a review of the facility provided policy and procedure (P&P) titled, Resident Hydration and Prevention of Dehydration last reviewed on 1/16/2026, the P&P indicated the facility will strive to provide adequate hydration and to prevent dehydration. The P&P further indicates for nurses' aides (CNA's) to provide and encourage intake of bedside, snack and meal fluids on a daily and routine basis.		

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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 and record review, the facility failed to provide two of three sampled residents (Resident 13 and Resident 42) reviewed under the respiratory care area, with necessary respiratory care services consistent with professional standards of practice by failing to: 1. Ensure Resident 13 and Resident 42 had a physician order for oxygen prior to administering oxygen to Resident 13 and 42. 2. Ensure Resident 42's nasal cannula and oxygen set-up was labeled with a date and changed weekly per facility policy. These deficient practices had the potential to place Resident 13 and Resident 42 at increased risk for infection and cause complications associated with oxygen therapy. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the facility originally admitted Resident 13 on 11/25/2022, and re-admitted the resident on 5/5/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). During a review of Resident 13's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/5/2025, the MDS indicated Resident 13 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required supervision from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent observation and interview on 1/12/2026 at 12:22 p.m., with Resident 13 inside the room, observed Resident 13 receiving oxygen at four (4) liters per minute (LPM) via nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of oxygen). Resident 13 stated, I use oxygen at all times. During a review of Resident 13's care plan (CP), revised on 10/23/2025, the CP indicated that Resident 13 has an oxygen therapy related to ineffective gas exchange with an intervention to give medication as ordered by the physician. During a concurrent interview and record review with Registered Nurse 2 (RN 2) on 1/12/2026 at 12:30 p.m., Resident 13's physician orders were reviewed. RN 2 stated Resident 13 did not have an order for oxygen therapy and should have had an order prior to oxygen administration. During an interview with the Director of Nursing (DON) on 1/15/2025 at 12:39 p.m., the DON stated that a physician order for oxygen therapy should have been obtained and documented in Resident 13's medical record prior to oxygen administration. 2. During a review of Resident 42's admission Record, the admission Record indicated the facility originally admitted Resident 42 on 8/26/2022, and re-admitted the resident on 1/23/2025 with diagnoses including atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow), atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls) and generalized muscle weakness. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 has an intact cognition for daily decision-making and required moderate assistance from staff for ADLs. During a concurrent observation and interview on 1/12/2026 at 9:30 a.m., with Resident 42 inside Resident 42's room, observed an oxygen concentrator with an unlabeled nasal cannula and an oxygen sterile water dated 12/31/2025. Resident 42 stated she is using oxygen at night and when feeling anxious (feeling worried, nervous, or uneasy). During an interview on 1/12/2026 at 10:12 a.m., with Infection Preventionist Nurse (IPN), the IPN stated that all the oxygen equipment should be changed and dated every seven days to prevent germ buildup that could cause infections. During a concurrent interview and record review with the DON on 1/13/2026 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 5:00 p.m., Resident 42's physician orders were reviewed. The DON stated Resident 42's physician orders did not indicate an order for oxygen therapy. The DON stated that the resident should have been assessed to determine the need for oxygen and if indicated, a physician's order should have been obtained to ensure resident's safety During a concurrent interview with Respiratory Therapist 1 (RT 1) on 1/14/2026 at 12:00 p.m., RT 1 stated residents should not receive oxygen without a physician's order due to risk of unsafe self-dosing. RT 1 further stated oxygen set ups are changed every Wednesday and that all oxygen equipment should be labeled with the date when it was changed. During a review a review of facility's policy and procedures (P&P) titled, Charting and Documentation, reviewed on 1/16/2025, the P&P indicated, Services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition should be documented in the resident's medical record. During a review of facility's P&P, titled, Oxygen Administration, reviewed on 1/16/2025, the P&P indicated, To verify that there is a physician order for oxygen when preparing to provide oxygen administration. During a review of facility's P&P, titled, Changing of Nasal Cannula/Oxygen Tubing, reviewed on 1/16/2025, the P&P indicated, It is the policy of the facility to change the nasal cannula and oxygen tubing weekly and as needed if soiled or damaged. P&P also indicted, Set up bags are dated and placed with each nasal cannula to prevent the nasal cannula from touching the floor when not being used.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to ensure one of three Certified Nursing Assistants (CNA 7) investigated for competency skills, possessed the competencies (a measurable pattern of knowledge, skills, abilities, behaviors that an individual needs to perform work roles successfully) necessary to perform their job roles. This deficient practice had the potential for staff to perform care incorrectly and not according to a resident's plan of care. Findings: During an interview and record review with the Director of Staff Development (DSD) on 1/14/2026 at 3:41 p.m., the DSD reviewed CNA 7's Competency Assessment. The assessment indicated CNA 7 was hired on 4/03/2024 and the competency assessment was completed on 8/09/2025. The DSD stated certified nursing assistants should have skills validation completely annually (every 12 months). The DSD stated that since CNA 7 started on 4/03/2024, the competency assessment should be done by 4/03/2025, not 8/09/2025. The DSD stated this is important to do every year to validate their performance skills, to ensure CNAs are doing their tasks according to the regulations, and to perform correctly and safely. During a record review with the DSD on 1/15/2026 at 8:15 a.m., the DSD reviewed the facility's Policy and Procedure titled, Competency of Nursing Staff, last reviewed 1/16/2025. The DSD read the policy which indicated facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. During an interview with the Director of Nurses (DON) on 1/15/2026 at 8:30 a.m., she stated skills competencies for licensed nursing staff and certified nursing assistants should be completed annually. The DON stated this is important to ensure staff are able to perform their duties and to have further training if necessary. ^^		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to ensure a resident's Diet Requisition Form was completed timely for one of five sampled residents (Resident 130) observed during breakfast. This resulted in the facility delivering Resident 130's breakfast tray two hours later than the other residents and only after the facility was informed of the resident's complaint of not getting her breakfast. This deficient practice had the potential to result in decreased meal intake which could lead to weight loss and malnutrition (lack of sufficient nutrients in the body). Findings: During a review of Resident 130's admission Record, the admission Record indicated the facility admitted the resident on 1/11/2026 with diagnoses including muscle weakness and history of falling. During a review of Resident 130's History and Physical dated 1/12/2026, indicated that the resident has the capacity to understand and make decisions. During a concurrent observation and interview on 1/12/2026 at 9:15 a.m., observed Resident 130 in bed and no breakfast tray. Resident 130 stated that she's trying to call her doctor and is just waiting for her breakfast. Resident 130 stated that she is a bit hungry and wondering why her breakfast was not delivered yet when her roommate's tray was delivered about two hours ago. During a concurrent observation and interview on 1/12/2026 at 10:26 a.m., with the Registered Dietitian (RD), observed the RD leaving Resident 130's room with the breakfast tray on hand. The RD stated that Resident 130's Diet Requisition Form was not forwarded to the kitchen last night or before breakfast this morning to ensure Resident 130 got her tray on time. The RD then later provided a copy of Resident 130's Diet Requisition Form that the kitchen received which had a date of 1/12/26 at 9:20 a.m. The RD stated that Resident 130's Diet Requisition Form was not timely forwarded to the kitchen hence the delay of Resident 130's breakfast. During a concurrent interview and record review on 1/14/2026 at 9:52 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 130's Diet Requisition Form. The ADON stated that upon admission the Diet Requisition Form should be completed and forwarded to the kitchen to ensure that the resident does not miss any meal. The ADON stated that if a resident does not get his/her meal tray on time, the resident could get a headache, dehydrated, and even hypoglycemia (low blood sugar) which can lead to a change in condition such as loss of consciousness and result to a fall and sustain an injury. During a review of the facility's Meal Times, the Meal Times indicated the following schedule: Breakfast: 7:30 a.m. - 8:30 a.m. Lunch: 11:45 a.m. - 12:45 a.m. Dinner: 5:30 p.m. - 6:30 p.m. During a review of the facility's policy and procedure (P&P) titled, Interdepartmental Notification of Diet-Including Changes and Reports, last reviewed on 1/16/2025, the P&P indicated that Nursing services shall notify the food and nutrition services department of a resident's diet order, including changes in the resident's diet, meal service, and food preferences. when a new resident is admitted, or a diet has been changed, the nurse supervisor shall ensure that the food and nutrition services department receives a written notice of the diet order.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by failing to ensure there were no soiled gloves and masks on the floor area and surroundings of the facility's dumpster. This deficient failure had potential to attract birds, flies, insects, pests, and possibly spread infection to 120 of 120 facility residents. Findings: During a concurrent observation and interview on 1/13/2026 at 10:34 a.m., with the HKD, observed multiple used gloves and masks on the floor of the surrounding area of the dumpster bins. The HKD stated that the surrounding area of the dumpster should be clean due to infection control. During a concurrent observation and interview on 1/15/2026 at 12:27 p.m., with the IPN, observed the same multiple used gloves and masks on the floor of the surrounding area of the dumpster bins. The IPN stated that the facility should maintain cleanliness, without any trash on the floor due to high risk of infection. During a review of the facility's P&P titled, Infection Prevention and Control, reviewed on 1/16/2025, the P&P indicated, The facility will maintain a safe, sanitary, and comfortable environment and prevent and manage transmission of diseases and infections. During a review of facility's P&P titled, Grounds, reviewed on 1/16/2025, the P&P indicated, Facility grounds shall be maintained in a safe and attractive manner. Housekeeping shall be responsible for keeping the grounds free of litter.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control measures by failing to: 1. Ensure Smoker Aid 1 (SA 1) performed hand hygiene (the practice of cleaning and disinfecting one's hands to remove dirt, germs, and bacteria) prior to scooping out ice and serving it to one of one sampled resident (Resident 13). 2. Ensure Housekeeper 2 (HK 2) wore an isolation gown (type of personal protective equipment [PPE- specialized clothing or equipment worn by an employee for protection against infectious materials] used in healthcare settings to protect healthcare personnel from the spread of infection or illness, particularly from contact with blood and body fluids) when cleaning a resident's room who was on enhanced barrier precautions (EBP -a set of infection control practices that use PPE to reduce exposure to reduce the spread of multidrug-resistant organisms [MDROs -microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for one of one sampled resident (Resident 12). These deficient practices had the potential to increase the risk of spreading infection to other residents and staff. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the facility originally admitted the resident on 11/25/2022 and readmitted the resident on 5/5/2025 with diagnoses including difficulty walking, and acute respiratory failure (a sudden, life-threatening condition where the lungs can't get enough oxygen into the blood stream). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 11/5/2025, the MDS indicated Resident 13 could make himself understood and understood others and required supervision from facility staff for tasks such as showering, lower body dressing and putting on/taking off foot ware. During an observation on 1/13/2026 at 9:31 a.m., observed Smoker Aid 1 (SA 1) assisting residents with their seats and cigarettes and then got up, opened the door handle to enter the dining room and then used the ice scoop to remove ice from the ice chest. SA 1 then opened the door handle again and served ice to Resident 13 without washing or sanitizing their hands before or after serving the ice. Observed a bottle with the words hand sanitizer on the table near SA 1. SA 1 continued to assist other residents in the smoking patio without sanitizing SA 1's hands. During an interview on 1/13/2026 at 9:39 a.m. with SA 1, SA 1 stated his role is to stay out in the smoking patio and supervise the residents that smoked. SA 1 stated they have hand sanitizer and normally uses it but forgot this time. SA 1 stated it is very important to wash or sanitize his hands between assisting different residents to help prevent the spread of germs. During an interview on 1/15/2026 at 12:41 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she was the nursing supervisor for that day. RN 1 stated she expected staff to perform hand hygiene before and after any contact with residents to prevent the spread of infection. RN 1 stated if nurses did not perform hand hygiene between resident contact, then it can lead to the spread of infection amongst residents. During a review of the facility's policy and procedure (P&P) titled, Hand Washing/Hand Hygiene, last reviewed and revised on 1/16/2026, the P&P indicated that the facility considered hand hygiene as the primary means to prevent the spread of infection. Personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Terrace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7447 Sepulveda Blvd 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visitors. During a review of the facility's P&P, Overview of Infection Control, last reviewed and revised on 1/16/2026, the P&P indicated for staff to use standard precautions including performing hand hygiene before and after any healthcare or cleaning tasks. The P&P stated alcohol-based sanitizers are used to sanitize hands when they are not visibly dirty, but when hands are visibly soiled washing hands with soap and water are the most effective. The P&P further stated to lather hands by vigorously rubbing them together with soap for at least 20 seconds. 2. During a review of Resident 12's admission Record, the admission Record indicated the facility originally admitted the resident on 7/12/2025 and re-admitted the resident on 10/23/202 with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] function stop functioning on a permanent basis) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). During review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 12's Order Summary Report dated 1/2/2026, the Order Summary Report indicated an order for Resident 12 to be on EBP. During a review of Resident 12's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) dated 1/2/2026, the care plan indicated that Resident 12 requires EBP with interventions to wear gloves and gowns when cleaning environmental surfaces. During a concurrent observation and interview on 1/13/2026 at 10:10 a.m., with HK 2, observed HK 2 cleaning Resident 12's room and not wearing an isolation gown. HK 2 stated that she (HK 2) was supposed to wear both gloves and an isolation gown when cleaning an EBP room. During an interview on 1/13/2026 at 10:15 a.m., with the Housekeeping Director (HKD), the HKD stated when cleaning an EBP room, housekeepers are supposed to be wearing gowns and gloves due to risk of infection. During an interview on 1/14/2026 at 10:11 a.m., with the Infection Preventionist Nurse (IPN), the IPN (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it is important that staff wear gloves and gowns when providing high contact care with the residents on EBP especially during environmental cleaning since these residents are at high risk for infection. ^ During a review of the facility's P&P titled, Infection Prevention and Control, reviewed on 1/16/2025, the P&P indicated, The facility will maintain a safe, sanitary, and comfortable environment and prevent and manage transmission of diseases and infections. ^ During a review of facility's P&P titled, Enhanced Standard/Barrier Precautions, reviewed on 1/16/2025, the P&P indicated, Personal protective equipment (PPE) is necessary when performing high-contact care activities. ^ During a review of the facility's door signage, titled, Enhanced Barrier Precautions, undated, EBP door signage indicated, Providers and staff must wear gloves and gown when providing high-contact resident care activities such as ADLs, caring for devices and medical treatments, mobility assistance and preparing to leave room, toileting and changing incontinence briefs, wound care and cleaning the environment.		