STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056076	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANAHEIM TERRACE CARE CENTER	**141 SOUTH KNOTT AVENUE ANAHEIM, CA 92804**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical record for one of two sampled residents (Resident 1) was accurate. * RN 3 documented Resident 1's vital signs even though the vital signs were not checked. * RN 1 failed to document when Resident 1 refused the medication administration. These had the potential for the resident's care needs to not be met. Findings: Review of P&P titled Nursing Documentation dated revised 11/1/19, showed documentation is to follow the guidelines of good communication and be concise, clear, pertinent, and accurate. Nursing staff will not falsify or improperly correct nursing documentation. Nurses will not document services that were not performed, before they are performed, and after the nursing documentation of a coworker. Medical record review for Resident 1 was initiated on 7/16/20. Resident 1 was admitted to the facility on [DATE]. Resident 1 was identified to be alert and able to make his needs known. a. Review of the complaint filed by Resident 1 to CDPH, L&C Program dated 7/9/20, showed the facility documented his vital signs on 7/6/20, even though they were not checked by facility staff on 7/6/20. Review of the Medication Administration Record [REDACTED]. There was documentation dated 7/6/20, of Resident 1's respiratory rate, temperature, and oxygen saturation level were within normal range. On 7/16/20 at 1230 hours, an interview and concurrent medical record review was conducted with the Administrator. The Administrator verified the above findings and stated Resident 1 had expressed the same concern to her and the facility's investigation showed the staff did not take Resident 1's vital signs on 7/6/20, between 2300 to 0700 hours because Resident 1 was asleep. Review of the Statement Sheet written by RN 3 dated 7/7/20, showed on 7/6/20, RN 3 was assigned to Resident 1. RN 3 acknowledged in her statement Resident 1's vital signs were not taken because the resident was sleeping. However, Resident 1's vital signs were recorded in the computer. The resident was not identified to have any change of condition and therefore, staff assume his vital signs were within normal range because Resident 1 did not have a change in condition. b. On 8/6/20 at 1440 hours, a telephone interview was conducted with Resident 1. Resident 1 stated he did not receive his medications as scheduled on 8/5/20 at 2100 hours. Resident 1 stated he could not remember what the medications were but knew he did not receive them. Review of the Medication Review Report for August 2020 showed the following orders dated 2/17/20: - Eliquis (anticoagulant) 5 mg one tablet by mouth every 12 hours; - simvastastin (cholesterol medication) 20 mg one tablet by mouth at bedtime; and - [MEDICATION NAME] cream (topical anesthetic) 4 % apply to bilateral knees topically in the evening for pain management. Review of the Medication Administration Record [REDACTED]. All three medications were not signed as being administered on 8/5/20. On 8/6/20 at 1645 hours, a telephone interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the above findings and stated the medications were not administered because Resident 1 refused the medications. The DON stated the licensed nurse forgot to document the resident's refusal.

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

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.