STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555671	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TERRACE VIEW CARE CENTER	**201 EAST BASTANCHURY FULLERTON, CA 92835**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to complete the request to formulate an advance directive for one of two sampled residents (Resident 1). This had the potential for the resident's decision regarding their healthcare and treatment options not being honored. Findings: Closed medical record review for Resident 1 was initiated on 4/16/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Advance Directive Acknowledgement dated 3/7/2020, showed Resident 1 had not executed an advance directive and would like to receive additional information. The form showed a handwritten note dated 3/10/2020, showed .discussed with resident's son on how to execute an advance directive. He will visit in a day or two and will assist him with papers. Review of the Social Services assessment dated [DATE], showed Family Member 1 was listed as Resident 1's power of attorney. The assessment showed Resident 1 was oriented to person, place, time, and situation. Review of Resident 1's MDS dated [DATE], showed Resident 1 had moderate cognitive impairment. On 5/15/2020 at 1500 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with the SSD. The SSD verified the above findings. The SSD stated upon admission, the residents were asked if they had an advance directive or if they were interested in formulating an advance directive. The SSD stated social services department was to provide the information regarding advance directives to the residents who were interested and was to contact the Long-Term Care Ombudsman to assist with the completion of an advance directive for the residents The SSD verified Resident 1 requested information and assistance on how to formulate an advance directive. The SSD stated Family Member 1 brought in a blank DPOA (durable power of attorney) form. She informed him the forms were not valid because they needed to be filled out and notarized, or have the Long-Term Care Ombudsman witness the signing of the form. The SSD stated she gave the forms to Family Member 1 to discuss with Resident 1. When asked if she discussed the DPOA paperwork with Resident 1, the SSD stated no. When asked if she followed-up about the DPOA paperwork with Family Member 1 and the Long-Term Care Ombudsman, the SSD stated no. The SSD acknowledged the DPOA paperwork for Resident 1 was never completed.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure two of two sampled residents (Residents 1 and 2) were discharged safely. * The facility failed to ensure Resident 1 was discharged with the physician's orders [REDACTED]. The facility failed to include the home health contact information on the resident's post-discharge plan of care. In addition, the facility failed to follow the physician's orders [REDACTED]. * The facility failed to accurately give instructions for two of Resident 2's medications according to the physician's discharge summary. This failure has the potential to cause dehydration, dizziness, weakness and/or [MEDICAL CONDITION]. These failures posed the risk for the residents not meeting the necessary care and treatment after being discharged from the facility. Findings: 1. Closed medical record review for Resident 1 was initiated on 4/16/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's physician's orders [REDACTED]. physician) dated 3/25/2020, showed to start [MEDICATION NAME], inject 10 units subcutaneously (under the skin) at bedtime. Preset the [MEDICATION NAME] injector pens at 10 units so the resident did not have to adjust the dosage at home. Review of Resident 1's Post Discharge Plan of Care dated 3/27/2020, failed to show the appointment with the Vascular Surgeon was included in the discharge instructions. The area for home health skilled nurse for medication management, skilled therapy (PT/OT), and home health aide to assist with bathing, were checked off. However, the contact information of the home health agency, to include name, address, telephone number and contact person, were left blank. Review of Resident 1's Medication List and Instructions dated 3/27/2020, failed to show an instruction whether the [MEDICATION NAME] injector pen was preset to 10 units as ordered by the physician. On 5/5/2020 at 1340 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with LVN 3. LVN 3 verified the above findings and stated she discharged Resident 1 home. LVN 3 stated the night shift nurse completed the post discharge plan of care form for Resident 1. When asked if she discussed with Resident 1 the appointment with the Vascular Surgeon on 4/3/2020, LVN 3 stated no. When asked if she provided the home health agency's information to Resident 1, LVN 3 stated no. When asked if she followed the physician's instruction to preset the [MEDICATION NAME] injector pens to 10 units, LVN 3 stated no, she was not aware of the instruction to preset the [MEDICATION NAME] injector pens. When asked if she reviewed the medical records for any appointments, and physician's instructions for Resident 1, LVN 3 stated no. LVN 3 stated she only discussed whatever was written on the post-discharge plan of care, and the medication list with Resident 1. 2. Closed medical review was initiated for Resident 2 on 4/16/2020. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Physician's Telephone Orders dated 4/6/2020, showed Resident 2 was to be discharged home on[DATE]. Review of Resident 2's Medication List and Instructions dated 4/9/2020, showed the instructions for Resident 2 to take [MEDICATION NAME] (medication for heart failure) 20 mg one tablet every day at 0900 hours for swelling management and potassium chloride ER (extended release) 10 mEq one tablet every day at 0900 hours for potassium supplement. Review of Resident 2's SNF Discharge form dated 4/8/2020, showed Resident 2's physician had changed the previous order for [MEDICATION NAME] 20 mg one tablet daily to [MEDICATION NAME] 20 mg one tablet daily as needed for extremity swelling. In addition, Resident 2's physician had changed the previous order for potassium chloride ER 10 mEq one tablet every day to potassium chloride ER 10 mEq one tablet daily as needed when taking [MEDICATION NAME]. On 5/1/2020 at 0954 hours, an interview and concurrent closed medical record review for Resident 2 was conducted with LVN 1. LVN 1 was asked where she would get information regarding a resident's discharge medication list. LVN 1 stated the physician's discharge summary. LVN 1 was asked to check Resident 2's discharge Medication List and Instructions and the physician's discharge summary. LVN 1 verified the above discrepancy and acknowledged the instructions should have identified the [MEDICATION NAME] and potassium chloride were to be taken as needed and not to be taken daily.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of two sampled residents (Resident 1). * Resident 1 had a physician's orders [REDACTED].

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) However, this order was omitted during the admission process to the facility. * Resident 1 had two orders for [MEDICATION NAME] (long-acting insulin used to treat diabetes) at bedtime. The facility failed to ensure the [MEDICATION NAME] injections were administered properly and consistently to Resident 1. These failures posed the risk of adverse effects to Resident 1's well-being. Findings: Closed medical record review for Resident 1 was initiated on 4/16/2020. Resident 1 was admitted to the facility on [DATE]. a. Review of the acute care hospital's Transfer Medication Reconciliation dated 3/7/2020, showed to administer naltrexone 50 mg one tablet by mouth daily. Review of Resident 1's Order Summary Report dated 3/8/2020, failed to show the order for naltrexone 50 mg by mouth daily. Review of the Progress Notes showed an Admission Summary entry dated 3/7/2020. The documentation failed to show the licensed nursing staff had clarified with the resident's physician about the order for naltrexone. Review of the Medication Administration Record [REDACTED]. Review of Resident 1's medical record failed to show the naltrexone medication was discontinued by the physician. On 5/5/2020 at 1600 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with LVN 4. LVN 4 stated she was the nurse who admitted Resident 1 on 3/7/2020. LVN 4 stated she used the Transfer Medication Reconciliation list from the acute care hospital to verify the orders with the physician. LVN 4 verified the Transfer Medication Reconciliation list included a physician's orders [REDACTED]. LVN 4 acknowledged she did not include naltrexone medication for Resident 1 during the admission process. LVN 4 stated Resident 1 requested to discontinue naltrexone. LVN 4 stated she clarified with the physician to discontinue the naltrexone. However, when asked to provide documentation when she clarified with the physician to discontinue the naltrexone, LVN 4 could not provide any documentation. On 5/5/2020 at 1630 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON verified the above findings. The DON stated the licensed nursing staff who admitted Resident 1 reviewed the medication list from the hospital, and if the resident requested to discontinue or refuse any of the medications, the licensed nursing staff had to notify the physician and was to document in the resident's medical record. The DON verified there was no documentation the physician was notified when Resident 1 requested the naltrexone medication to be discontinued. b. Review of Resident 1's Order Summary Report showed a physician's orders [REDACTED]. Review of Resident 1's Physician's Telephone Orders dated 3/16/2020, showed an order to add insulin [MEDICATION NAME] 10 units at bedtime. Review of Resident 1's Medication Administration Record [REDACTED]. On 3/16, 3/20, 3/21, 3/22, 3/24, and on 3/26/2020, Resident 1 was administered the [MEDICATION NAME] 10 units and [MEDICATION NAME] 12 units injections on separate injection sites at the same time (2100 hours). In addition, the Medication Administration Record [REDACTED]. For example, on 3/18, 3/19, 3/23, and 3/25/2020, Resident 1 was administered [MEDICATION NAME] 12 units injections, but was not administered the [MEDICATION NAME] 10 units injection. On 5/5/2020 at 1630 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON verified the above findings. The DON verified Resident 1 had two orders for [MEDICATION NAME] injections. The DON stated the physician's orders [REDACTED]. The DON stated the licensed nurse who took the order should have combined the order for 10 and 12 units of [MEDICATION NAME] injections to avoid confusion. The DON verified the physician's orders [REDACTED]. The DON could not explain why Resident 1 did not receive the [MEDICATION NAME] 10 units but received the [MEDICATION NAME] 12 units on 3/18, 3/19, 3/23, and 3/25/2020.