STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055070	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to notify the physician that one of one resident (Resident 1) has been noncompliant with taking Risperidone (medication is used to treat certain mental/mood disorders) 0.25 milligrams every 8 hours as ordered. This deficient practice had the potential to result in the delay of care for Resident 1 who may need alternative treatment measures prescribed by the physician due to noncompliance of taking the Risperidone. Findings: During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including malignant neoplasm (abnormal growth of tissue or cancerous tumor) of the right breast, schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/28/2024, the MDS indicated Resident 1 was rarely understood and cognitive (thinking) skills for daily decision making was severely impaired. During a review of Resident 1's Order Summary Report, as of 8/113/2024, the report indicated, starting 7/29/2024, to administer Risperidone 0.25 milliliters (0.25 milligrams) by mouth every 8 hours for bipolar disorder manifested by hitting staff and agitation. During an interview review on 8/13/2024 at 9:12 a.m. with the Director of Staff Development (DSD) and record review of Resident 1's Medication Administration Record (MAR), for 7/2024 and 8/2024, Resident 1's MAR, from 7/29/2024 10:00 p.m. to 8/13/2024 at 6 a.m., indicated Risperidone 0.25 mg was refused twice in July and nine times in August, and Resident 1 spit out meds three times during the timeframe. There was no documented evidence Resident 1's physician was notified of Resident 1's noncompliance with taking for Risperidone. The DSD stated there was no documented evidence of the physician being notified of Resident 1's noncompliance with taking risperidone and refusing risperidone that can cause of her increased agitation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER: Seacrest Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1416 West 6th Street San Pedro, CA 90732	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 8/13/2024 at 9:47 a.m., the DON stated staff needed to notify the physician of refusals of medications so the physician can make plans of treatment for the resident. During a review of the facility's policy and procedure (P&P) titled, Refusal of Medications and Treatments, Documentation of, revised 12/2006, the P&P indicated repeated refusals shall be reported to the Director of Nursing Services and the physician. The P&P indicated the documentations related to resident refusal shall include at least the following: A. the date and time the staff tried to give the medication. b. the medication they tried to give. c. the resident response and reason for refusal d. name of person attempting to administer the treatment and that the resident was informed (to the extent of their ability to understand) about the purpose of the treatment and the consequences of not receiving the medication or treatment. e. The resident's condition and any adverse effects due to the refusal f. if the physician was notified as well as the physician response. g. other pertinent observations. During a review of the facility's policy and procedure (P&P) titled, Requesting, refusing, and/or Discontinuing Care or Treatment, revised 2/2021, the P&P indicated detailed information relating to the refusal are documented in the resident's medical record including the date and time the practitioner was notified as well as the practitioner's response. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the noncompliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to develop care plan for one of one resident ' s (Resident 1) noncompliance with care. This deficient practice had the potential to result in the delay of care for Resident 1 who may need alternative interventions and measures. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including malignant neoplasm (abnormal growth of tissue or cancerous tumor) of the right breast, schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/28/2024, the MDS indicated Resident 1 was rarely understood and cognitive (thinking) skills for daily decision making was severely impaired. During a review of resident 1 ' s Interdisciplinary team (IDT) Plan of care meeting, dated 5/24/2024, the IDT meeting notes indicated Resident 1 had episodes of refusing medications, and refusing to eat. During a review of Resident 1 ' s History and Physical, dated 7/29/2024, the H&P indicated Resident 1 tend to refuse care, wound care, even with mother present. The H&P indicated lately resistance/ refusal of general care including hygiene has been increasing. During an interview on 8/13/2024 at 8:39 a.m. with the Director of Staff Development (DSD) and record review of Resident 1 ' s care plan. Resident 1 did not have care plans addressing Resident 1 ' s noncompliance. The DSD stated Resident 1 needed a noncompliance care plan so there ' s interventions to address the resident ' s behavior issues. During an interview with the Director of Nursing (DON) on 8/13/2024 at 9:47 a.m., the DON stated staff needed to create a care plan addressing Resident 1 ' s noncompliance. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person-Centered, revised 3/2022, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 44055 Based on interview and record review the facility failed to provide quality care in accordance with professional standards of practice when the facility failed to ensure one of one resident ' s (Resident 5) lower extremities edema (fluid retention in the body) was assessed after it was identified on 6/21/2024. This deficient practice had the potential to result in unidentified complications with worsening edema and result in poor resident health outcomes. Findings: During a record review of Resident 5 ' s Admission Record, the admission record indicated Resident 5 was admitted to the facility on [DATE] with diagnosis including type 2 diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy), contusion (bruise) of lower back, hypertension (condition in which the force of the blood against the artery walls is too high), difficulty walking, muscle weakness, and atherosclerosis (buildup of fats, cholesterol and other substances in and on the artery walls) of aorta (main blood vessel of the body). During a record review of Resident 5 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/5/2024, the MDS indicated Resident 5 had intact cognition (ability to think and reason). The MDS indicated Resident 5 needed set up assistance when eating, partial assistance (helper does less than half the effort) with personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, dressing, and dependent with showering/ bathing. During a record review of Resident 5 ' s Health status note, 6/21/2024 at 9:07 p.m., the note indicated Resident 5 was in bed with legs elevated, 4+ pitting (grade 4 edema, the most severe type, is defined as having a pit anywhere over 6 millimeters in depth, taking over 30 seconds to rebound) edema to bilateral legs. During an interview and record review on 8/13/2024 at 7:30 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 5 ' s medical records from July to August including nursing weekly summaries (assessments), nursing progress notes, and nursing change of condition documentations. There was no documented description of Resident 5 ' s edema assessment at least weekly in July or August. LVN 2 stated at the least, the weekly summary should include a description of Resident 5 ' s edema since it was an ongoing problem. LVN 2 stated edema assessment included a documentation of a. the location, b. pitting or nonpitting (when a swollen part of your body has a dimple (or pit) after you press it for a few seconds), c. the grade of the edema. (1-4, grading system of edema to determine severity from scale of +1 to +4) and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. pedal pulses (pulse on top of the foot) LVN 2 stated edema assessment was needed to see if the edema was getting better or worse. During an interview with the Director of Staff Development (DSD) on 8/13/2024 at 8:39 a.m. the DSD stated if the assessment was not documented it was not done. And we won ' t know if the edema was improving or not. During an interview with the Director of Nursing (DON) on 8/13/2024 at 9:47 a.m., the DON stated edema assessment should be documented. The DON stated Weekly summary was a nursing assessment of the resident so the edema description should have been documented weekly from July to August. The DON stated edema assessment was a cardiovascular (refers to the heart and blood vessels that make up the circulatory system, which circulates blood throughout the body) assessment that we will incorporate into facility practice. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated assessments of residents were ongoing. During a review of the facility ' s policy and procedure P&P titled Resident Examination and Assessment, Revised 2/2014, the P&P indicated the purpose of this procedure was to examine and assess the resident for any abnormalities in health status, which provides the basis for the care plan. The P&P indicated the physical exams includes skin assessment for the presence of edema. The P&P indicated the assessment will be recorded in the resident ' s medical record: The date and time the procedure was performed. The name and title of the individual who performed the procedure, all assessment data obtained.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of one resident ' s (Resident 5) echocardiogram (imaging test that checks the structure and function of the heart) was completed as ordered on 6/22/2024. This deficient practice resulted in a delay of care that had the potential to result in a continued undiagnosed heart problem for Resident 1. Findings: During a review of Resident 5 ' s Admission Record, the admission record indicated Resident 5 was admitted to the facility on [DATE] with diagnosis including type 2 diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (condition in which the force of the blood against the artery walls is too high), difficulty walking, and atherosclerosis (buildup of fats, cholesterol and other substances in and on the artery walls) of aorta (main blood vessel of the body). During a review of Resident 5 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/5/2024, the MDS indicated Resident 5 had intact cognition (ability to think and reason). The MDS indicated Resident 5 needed set up assistance when eating, partial assistance (helper does less than half the effort) with personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, dressing, and dependent with showering/ bathing. During an interview and record review on 8/13/2024 at 7:51 a.m. with Registered Nurse 2 (RN 2), Resident 5 ' s written physician order dated 6/22/024. The order indicated Echocardiogram, lower extremity edema (fluid retention in the body), once. The order was noted by RN 2. RN 2 stated she noted the order and made a mistake because she ordered an electrocardiogram (recording of hearts electrical activity) and not an echocardiogram. RN 2 stated the echocardiogram should have been ordered because it was important to check for heart function and to check if it was contributing to the edema. During a review of the facility ' s policy and procedure P&P titled Availability of Services, Diagnostic, Revised 12/2009, the P&P indicated clinical radiology services to meet the residents ' needs are provided by the facility. Diagnostic services and radiology services are available twenty-four hours a day seven days a week including holidays as necessary. During a review of the facility ' s &P titled Request for Diagnostic Services, Revised 4/2007, the P&P indicated orders for diagnostic services will be promptly carried out as instructed by the physician order.