STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055208	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaview Rehabilitation & Wellness Center, LP	6400 Purdue Drive Eureka, CA 95503

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure the services of a Registered Nurse (RN) for at least eight consecutive hours per day, seven days a week for a census of 39.This failure had the potential for residents to have unmet care needs and services.Findings:A review of the facility's third quarter (4/1/25-6/30/25) Payroll Based Journal (PBJ) Staffing Data Report, printed on 9/15/25, indicated the facility did not have RN coverage on 4/5/25, 5/16/25, 5/23/25, 5/26/25 and 6/20/25.A review of the facility's Daily Staffing Sheet dated 4/5/25, 5/16/25, 5/23/25, 5/26/25 and 6/20/25, indicated no RNs were scheduled.During an interview with the Administrator (ADM) on 9/24/25 at 1:57 p.m. the ADM confirmed there had been several days when no RN had worked eight consecutive hours and stated it was important to have an RN for the supervision and clinical assessment of residents.During a review of the facility's policy and procedure (P&P) titled, Nursing Department- Staffing, Scheduling & Postings, dated 7/18, the P&P indicated, To ensure than (sic) adequate number of nursing personnel are available to meet resident needs.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, the facility failed to ensure person centered, comprehensive care for seven residents (Resident 7, Resident 6, Resident 3, Resident 39, Resident 24, Resident 34, and Resident 10) out of a census of 36 when the Interdisciplinary Team (IDT-a group of healthcare professionals collaborating to develop and implement a resident centered treatment plan) did not plan quarterly care conferences or involve residents and/or Responsible Party (RP, a person or entity responsible for making healthcare decisions).These failures resulted in lost opportunities for the residents to be included in decisions regarding their care, treatment and interventions.Findings: A review of Resident 7's Multidisciplinary Care Conference (MCC), dated 9/10/24, indicated a quarterly care conference was held without Resident 7's RP present. A further review of Resident 7's medical chart indicated Resident 7 had no quarterly care conference held for the 4th quarter of 2024. A review of Resident 6's MCC, dated 10/23/24, indicated a quarterly care conference was held without Resident 5 nor Resident 5's RP present. A further review of Resident 5's medical chart indicated Resident had no quarterly care conferences for the first or second quarter of 2025. A review of Resident 3's MCC, dated 3/4/25, indicated a quarterly care conference was held without Resident 3 nor Resident 3's RP present. A further review of Resident 3's medical chart indicated Resident 3 had no quarterly care conference held in the 4th quarter of 2024. During an interview on 9/22/25 at 8:42 a.m., the Ombudsman (OMS) stated she had not attended any care conferences recently due to turnovers in leadership. During an interview on 9/22/25 at 11:12 a.m. Resident 39 said, I usually get care conferences where they discuss my care but not lately. During a concurrent record review and interview on 9/25/25 at approximately 12:30 p.m., evidence of Resident 39's last care conference was requested. The Social Services Director (SSS) verified Resident 39 had no care conference since 9/20/24. During a concurrent interview and record review on 9/22/25 at 2:46 p.m., Resident 6's daughter stated she was his RP. She stated she had not been invited to participate in a care conference in almost a year. She stated this concerned her because she wanted to speak with his physician and the team about Resident 6's health status. A review of Resident 6's medical chart indicated no quarterly care conference was held in the 4th quarter of 2024. During a record review on 9/23/25 of Resident 24's chart, MCC forms indicated no quarterly care conferences were held for Resident 24 during the 2nd and 3rd quarters of 2025. During a record review on 9/23/25 of Resident 34's chart, the MCC forms indicated an initial care conference was not held for Resident 34. During a record review on 9/23/25 of Resident 10's chart, the MCC forms indicated an initial care conference was not held for Resident 10. During an interview on 9/23/25 at 10:54 a.m., the SSD stated she was responsible for coordinating (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly care conferences. The SSD stated prior to her accepting this position, quarterly care conferences were not completed for approximately one year. A review of the facility's policy titled Comprehensive Person-Centered Care Planning, dated November 2018 indicated, It is the policy of this facility to provide person-centered.interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.The IDT team will include.the resident and the resident's representative(s). An explanation must be included in a resident's medical record if participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

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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. Based on observation, interview, and record review, the facility failed to ensure accurate reconciliation, accountability and disposition (the process of returning and/or destroying unused medications) of controlled medications (medications with high potential for abuse or addiction) and medication administration for a census of 39 residents when:Random controlled medication audits for two residents (Resident 20, and Resident 36) did not reconcile. The medications were signed out of Individual Narcotic Record (INR, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Record (MAR) to indicate they were given to the residents; and,The Controlled Substance Disposition Log was not provided for medications that were destroyed on 7/17/25 and 8/21/25.These failures resulted in the facility not having an accurate accountability of controlled substances and increased the potential for diversion.Findings:1.The controlled medication record for two random residents (Resident 20 and Resident 36) who received as needed controlled medications were requested for review during the survey.A review of Resident 20's Order Summary Report [OSR], dated 4/10/25, indicated, Hydrocodone- Acetaminophen Tablet 5-325 mg: Give 1 tablet by mouth every 6 hours as needed for pain.A review of Resident 20's INR for Hydrocodone-Acetaminophen Tablet 5-325mg, indicated nursing staff had removed the following from the medication cart and documented on the INR without documenting the respective administration on the MAR: One tablet on 9/15/25 at 7:30 p.m., one tablet on 9/18/25 at 6:45 p.m., one tablet on 9/20/25 at 5:30 a.m., and one tablet on 9/22/25 at 6:30 p.m.A review of Resident 36's OSR dated 6/21/24, indicated, oxycodone HCl Oral Tablet 5 mg: Give 1 tablet by mouth every 4 hours as needed.A review of Resident 36's INR for Oxycodone 5 mg, indicated the nursing staff had removed the following from the medication cart and documented on the INR without documenting the respective administration on the MAR: One tablet on 9/1/25 at 8 p.m., one tablet on 9/3/25 at 5 p.m., one tablet on 9/15/25 at 8:12 a.m., and one tablet on 9/16/25 at 8 p.m. The MAR indicated one tablet was given to the resident on 9/21/25, but this medication was not removed from the medication cart.In an interview on 9/23/25 at 1:40 p.m. Licensed Nurse 2 (LN 2) stated when narcotics are given, they are signed out in the INR and documented in the MAR.During a concurrent interview and record review on 9/23/25 at 1:45 p.m. of Resident 20 and Resident 36's narcotic documentation with the Director of Nursing (DON), the DON confirmed the INR did not match the MAR. The DON stated she expected staff to follow the policy and document the narcotic in the MAR, If they [nurses] take it, they have to say what they did with it.A review of the facility's policy and procedure (P&P) titled, Medication- Administration, dated 6/25, indicated, .The time and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administered the medication or treatment.2. During a review of a facility provided document titled, CONTROLLED SUBSTANCE DISPOSITION LOG, the log indicated, Instructions: Upon receipt of the Narcotic Medication from the licensed nurse.the DON will complete this disposition log. The DON will also sign the Narcotic Bound Book. This log is maintained in a binder inside the Narcotic Drawer in the DONs office.A concurrent interview and record review on 9/24/25 at 9:17 a.m. of the narcotic disposition binder was conducted with the DON. The Controlled Substance Disposition Log for July and August were not in the binder. The DON confirmed the logs for both 7/17/25 and 8/21/25 were missing from the binder and stated it was important to keep an accurate account of narcotics. The DON stated, We need to know what comes in and what goes out and that nothing was taken. The DON stated she expected to see an accurate disposition record.In an interview on 9/24/25 at 12:18 p.m. the Regional Quality Management Consultant (RQMC) confirmed the logs were unable to be located. The RQMC stated it was important to have the Controlled Substance Disposition Logs so the facility would have a chain of custody of the narcotics. The RQMC stated she expected the log to be accurate, filled out by the DON and co-signed by the pharmacist.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to protect the health of nine residents (Resident 37, Resident 38, Resident 35, Resident 3, Resident 14, Resident 34, Resident 1, Resident 21 and Resident 22) out of a census of 36 residents when:1. Hand hygiene was not performed prior to dining; and,2. Toilet plungers were placed directly on resident bathroom floors without being in receptacles.These failures decreased the facility's potential to prevent resident illness.Findings: 1. During an observation on 9/22/25 at 1:03 p.m. in Resident 37's room, Resident 37 was provided with his lunch tray without offering hand hygiene prior. There was no hand wipes were noted on Resident 37's lunch tray. During an observation on 9/22/25 at 1:05 p.m., in Resident 38's room, Resident 38 was provided with his lunch tray without offering hand hygiene prior. There was no hand wipes were noted on Resident 38's lunch tray. During an observation in Resident 3's room on 9/22/25 at 1:08 p.m., Certified Nursing Assistant 2 (CNA 2) donned (put on) Personal Protective Equipment (PPE) without first performing hand hygiene to feed Resident 3. The CNA intermittently assisted Resident 3's roommate on three separate occasions, failing to change gloves or perform hand hygiene between interactions with the residents. During an observation in Resident 14's room on 9/22/25 at 1:12 p.m., CNA 1 positioned Resident 14 in a seated position while in bed. CNA 1 started to feed Resident 14 without performing hand hygiene prior. During an observation in Resident 34's room on 9/22/25 at 1:14 p.m., Minimum Data Set Coordinator (MDSC) entered Resident 34's room. The MDSC assisted Resident 34 to eat without offering hand hygiene prior. During an interview on 9/22/25 at 1:29 p.m., the Infection Preventionist (IP) recommended hand hygiene for both residents and staff prior to eating or feeding. The IP stated, The hands are the dirtiest things on our bodies. They [Residents and staff] touch things, then they put the germs right in their mouths. The IP stated hand hygiene is the most important practice to follow to mitigate the spread of illness. A record review of the facility's policy titled Hand Hygiene dated 1/1/12 indicated, The facility considers hand hygiene the primary means to prevent the spread of infection.Facility staff follow the hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors. 2. During a concurrent observation and interview on 9/22/25 at 9:36 a.m., CNA 4 verified a toilet plunger was sitting directly on the floor of the bathroom without a container to prevent contamination from bowel and bladder contamination and said, It should be stored in a container. They're supposed to have a receptacle to put it in. [Resident 21 and Resident 22] use that bathroom. During an observation on 9/22/25 at 10:05 a.m. there was a plunger observed sitting directly on the floor of the bathroom shared by Resident 1 and Resident 35 with no receptacle to catch the toilet drippings. During a concurrent observation and interview on 9/22/25 at 10:12 a.m. the IP verified a toilet plunger (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was placed directly on the floor of the bathroom shared by Resident 1 and Resident 35 and said, The plunger should not be directly on the floor. In an interview on 9/22/25 at 10:18 a.m. the Housekeeping Supervisor (HS) said, All plungers should be covered with a fresh plastic bag to keep the bacteria off the floor. The policy for storage of plungers in resident bathrooms was requested but not provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to follow physician orders for one of 14 sampled residents (Resident 22) when the oxygen order did not match the amount of oxygen the resident was administered.This failure caused Resident 22 to receive the incorrect amount of oxygen.Findings:A review of an admission record indicated Resident 22 was admitted to the facility in early 2022 with diagnosis which included chronic respiratory failure with hypercapnia (condition where the body fails to adequately remove carbon dioxide from the blood) and hypoxia (low levels of oxygen in your body tissues).A review of Resident 22's physician order dated 7/17/25 indicated, PRN [as needed] Oxygen @2L [liters]/min Via NC [nasal cannula] .A review of Resident 22's care plan initiated 1/10/24 indicated, [Resident 22] has oxygen therapy r/t [related to] Ineffective gas exchange.OXYGEN SETTINGS: O2 [oxygen] via NC @ 1-2L PRN.During an observation on 9/22/25 at 8:23 a.m. of Resident 22's oxygen concentrator, the oxygen was set to deliver 4L/min. A picture was taken of the oxygen concentrator with the resident's permission.During a concurrent observation and interview on 9/23/25 at 11:43 a.m. of Resident 22's oxygen concentrator setting with Licensed Nurse (LN 1), LN 1 confirmed the oxygen setting was at 4L/min. LN 1 reviewed the physician order in the electronic health record (EHR) and stated the order was for 2L /min. LN 1confirmed staff was not following the physician order for oxygen and stated it was important to follow the physician's order.During an interview and record review on 9/23/25 at 1:58 p.m., the Director of Nursing (DON) was shown a picture of Resident 2's oxygen concentrator set at 4L/min. The DON confirmed the physician order was for 2L/min. The DON stated nurses should follow the physician order and nurses were responsible to ensure what the patient received matched the order.A review of the facility policy and procedure (P&P) titled, Oxygen Therapy, dated 11/17, indicated, .Administer oxygen per physician orders.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide treatment and service to maintain or improve mobility for one resident (Resident 38) out of a census of 36 when Resident 38 did not receive Restorative Nurse Assistance (RNA-program designed to help residents maintain or regain maximum physical potential) sessions as ordered and was not evaluated for proper wheelchair height.This failure decreased the facility's potential to ensure Resident 38's ability to do activities of daily living (ADL, basic self-care tasks that are typically performed independently daily, i.e. dressing, bathing, toileting) did not diminish.Findings:A review of Resident 38's admission record indicated Resident 38 was admitted to the facility on [DATE] with a primary diagnosis of infection and inflammatory (part of the body becoming red, swollen, hot and often painful) reaction due to internal right hip prosthesis (artificial body part).A review of Resident 38's Section F-Preferences for Customary Routine and Activities of the Minimum Data Set (MDS-a federally mandated assessment tool) dated 6/26/25 indicated Resident 38 thought it was very important for him to participate in his favorite activities. A further review of this assessment indicated Resident 38 thought it was somewhat important for him to get fresh air when the weather was good and to participate in group activities with people.A review of Resident 38's Order Details, dated 7/18/25, indicated the RNA program was ordered for Resident 38 as follows, Active Range of Motion [resident moving joints through full range of motion without therapist assistance] to bilateral [both] extremities, ambulating with front rolling walker; 3 episodes per week.A review of Resident 38's progress note dated 7/29/25 at 4:18 p.m., indicated Resident 38 had joined the RNA program. A review of Resident 38's RNA documentation from 7/31/25 to 9/23/25 indicated Resident 38 did not receive RNA services three times per week as ordered.During a concurrent observation and interview on 9/22/25 at 9:23 a.m., Resident 38 was lying in bed with a hospital gown on with a healed amputation to Resident 38's right leg and partial hip area. Resident 38 stated he did not get out of bed much; however, would get out of bed and participate in more activities if his wheelchair was not so low. Resident 38 stated the wheelchair belonged to his sister-in-law, but it (the wheelchair) was too low for him to safely transfer out of his bed and propel himself out of the room. A wheelchair was observed folded and propped up against the wall. Resident 38 stated he was bored at times.During an interview on 9/23/25 at 11:30 a.m., the Administrator (ADM) stated the Physical Therapist (PT) was shared between three buildings and would come to the building when needed. The ADM further stated he cannot estimate how often PT worked at the facility. During an interview on 9/23/25, at 11:35 a.m., the PT stated evaluations for wheelchair height could be determined after the resident's weight, height and cognitive (relating to processes of thinking and reasoning) impairment was assessed. The PT further stated not having a wheelchair at the proper height posed a safety hazard for residents to fall and accidents occurred. During an interview on 9/24/25 at 12:50 p.m., the RNA stated she would try to work with Resident 38 two or three times per week but was occasionally pulled from her RNA duties to perform Certified Nursing Assistant (CNA) duties. RNA stated Resident 38's wheelchair is too low for him, and the PT was the only discipline who could determine a safe wheelchair height. The RNA further stated if a wheelchair was too low, a resident can get their legs caught up in the wheels or it would cause the resident to sit funny which would cause discomfort after sitting for a while.A review of the facility's document titled Restorative Nursing Program Guidelines, dated September 2019, indicated, Restorative care implies that the possibility for progress exists and that improvement can be expected.This program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.