STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056010	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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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 - Potential for minimal harm Residents Affected - Some	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** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to develop and implement the plan of care to reflect the individual care needs for one of five sampled residents (Resident 8). * The facility failed to ensure Resident 8 had a plan of care to address use of a CPAP. This failure posed the risk of not providing appropriate, consistent, and individualized care to the residents. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed 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. Closed medical record review for Resident 8 was initiated on 5/13/24. Resident 8 was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 8's H&P examination dated 4/22/24, showed Resident 8 had a diagnosis of obstructive sleep apnea. Review of Resident 8's Order Summary Report dated 5/13/24, showed the following physician's orders dated 4/19/24: - CPAP order # 1: CPAP use: At NOC and PRN respiratory distress, at bedtime - CPAP #2: Mask Type: Nasal Mask- to wash mask every morning in warm, soapy water and air dry, once a day - CPAP #3: Replace mask tubing accessories as needed for device degradation Review of Resident 8's plan of care failed to show a care plan problem addressing Resident 8's use of a CPAP at bedtime. (continued on next page)

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

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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 - Potential for minimal harm Residents Affected - Some	On 5/14/24 at 0805 hours, an interview and concurrent medical record review was conducted for Resident 8 with LVN 7. LVN 7 stated Resident 8 was on CPAP nightly, applied by the nurse on the 1500-to-2300-hour shift. LVN 7 further stated he was responsible for removing the CPAP at 0600 hours every morning. LVN 7 verified the above findings and stated Resident 8 should have a care plan addressing his use of CPAP to provide individualized care for the resident. On 5/14/24 at 1155 hours, the DON was informed and acknowledged the above findings.

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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** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure three of eight sampled residents (Residents 4, 8, and 9) were provided quality care when: * The facility failed to assess Resident 8, notify the physician, and document the change of condition regarding an unwitnessed fall. * The facility failed to ensure complete monitoring of the neurological status was conducted after a fall with head injury for Residents 8 and 9. * The facility failed to notify the physician related to the low oxygen saturation levels for Resident 8. * The facility failed to document and obtain a physician's order for a manual fecal disimpaction for Resident 4. * The facility failed to administer the PRN BM medications as ordered for Resident 4. These failures had the potential for delay in providing the necessary care and services to the residents. Findings: Review of the facility's P&P titled Falls and Fall Risk, Managing revised 3/2018 showed according to the MDS, a fall is defined as: unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occur. Review of the facility's P&P titled Falls-Clinical Protocol revised 3/2018, showed the nurse shall assess and document/report the following: a. vital signs, b. recent injury, especially fracture or head injury, c. musculoskeletal function, observing for change in normal range of motion, d. change in cognition or level of consciousness, e. neurological status, f. pain, g. frequency and number of falls since last physician visit, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. precipitating factors, details on how fall occurred, i. all current medications, especially those associated with dizziness or lethargy, and j. all active diagnoses. Further review of the P&P showed the staff will evaluate and document falls that occur while the individual is in the facility. Falls should be categorized as: those that occur while trying to rise from a sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor. Under the section Monitoring and Follow-up showed: the staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma (bleeding from a blood vessel in the space between the skull and the brain, the bleeding may lead to the formation of a blood clot that places pressure on the brain) have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or days after a fall. Review of the facility P&P titled Change in a Resident's Condition or Status (undated) showed the facility will promptly notify the resident, his or her attending physician, and the resident's representatives of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been an accident involving the resident. Review of the facility's P&P titled Neurological Assessment (Routine) revised 10/2023 showed routine neurological assessment is conducted to evaluate the resident for small changes overtime that may be indicative of neurological injury. Routine neurological exam includes assessing: mental status and level of consciousness, pupillary response, motor strength, sensation, and gait. Further review of the P&P showed to conduct neurological checks as frequently as ordered. The following information should 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, and all assessment data obtained during the procedure. 1. On 4/25/24 at 1600 hours, Resident 8 was observed lying on the mattress on the ground to the left of his bed. Closed medical record review for Resident 8 was initiated on 4/25/24. Resident 8 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 8's MDS dated [DATE], showed Resident 8 had moderately impaired cognition. Further review of the MDS showed Resident 8 had a fall in the last month prior to admission to the facility and multiple falls after admission to the facility. Review of Resident 8's plan of care showed a care plan problem dated 4/20/24, addressing Resident 8 was found lying on the floor, with behavior of going down to the floor. The interventions showed to provide frequent visual checks and place the mattress on the floor. Further review of Resident 8's plan of care showed a care plan problem dated 4/22/24, addressing Resident 8's risk for fall related to unsteadiness, poor weight bearing, cognitive impairment, and history of falls. Interventions showed to monitor resident safety and remind and reinforce safety awareness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's MAR for April 2024 showed on 4/25/24 at 1955 hours, Resident 8 was administered acetaminophen (pain medication) 325 mg one tablet by mouth for a pain level of three out of 10. Review of Resident 8's Progress Notes failed to show documentation a fall occurred on 4/25/24. On 5/1/24, the CDPH, L&C Program received a complaint from Resident 8's responsible party. The responsible party reported Resident 8 was on the floor in pain and the contracted sitter, who had arrived at 1900 hours, stated she had found the resident on the floor. The responsible party stated an RN was notified to assist in transferring the resident back to bed. On 5/15/24 at 0850 hours, a telephone interview was conducted with Sitter 1. Sitter 1 stated she was assigned to work as Resident 8's sitter on 4/25/24 from 1900 hours to 0700 hours. Sitter 1 stated when she arrived at 1900 hours, she found Resident 8 on the ground on a mattress. Sitter 1 stated the staff was not present in the room. Sitter 1 further stated she spoke to the facility staff who informed her the resident was a fall risk and due to his falls, the facility placed a mattress by his bed. On 5/16/24 at 0824 hours, a telephone interview was conducted with CNA 9. CNA 9 stated he was assigned to Resident 8 on 4/25/24 from 1500 to 2300 hours. CNA 1 stated he provided visual checks every hour to ensure Resident did not get out of bed. CNA 9 stated there were multiple occasions where he observed the resident on his bed, and the next time he checked, the resident was on the mattress on the ground. On 5/16/24 at 0913 hours, an interview was conducted with RN 3. RN 3 verified he worked on 4/25/24. RN 3 stated around 1900 to 1930 hours, he was informed by a CNA Resident 8 was on the ground. RN 3 stated when he arrived in Resident 8's room, Resident 8 was lying on his back on the mattress on the ground and was groaning in pain. RN 3 stated all the male CNAs (including CNA 9) were on their lunch break, thus it took some time to transfer the resident back to bed. RN 3 was asked to define a fall. RN 3 stated a fall was anytime the resident is found on a lower surface. RN 3 was asked if the height of Resident 8's bed was at the same level as the height of the mattress on the ground. RN 3 stated the mattress on the ground was at a lower level. RN 3 was asked if Resident 8 was considered to have fallen. RN 3 stated yes. RN 3 was asked about the protocol for falls. RN 3 stated for all falls, the resident would be assessed, the physician would be informed, and if unwitnessed, neuro checks should be initiated. RN 3 further stated the charge nurse would be responsible for the Change of Condition assessment and informing all parties involved. On 5/16/24 at 0927 hours, an interview and concurrent closed medical record review for Resident 8 was conducted with RN 3. RN 3 verified there was no documentation of Resident 8's fall on 4/25/24. On 5/16/24 at 1043 hours, a phone interview was conducted with LVN 5. LVN 5 stated she recalled the day she was informed by a CNA to go Resident 8's room. When she arrived, Resident 8 was on the mattress on the ground. LVN 5 stated she recalled RN 3 searching for staff to assist with transferring the resident back to bed. LVN 5 stated the last time she saw the resident; he was in bed. LVN 5 stated the bed and the mattress on the ground were not at the same level, but were close, so she did not consider it a fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 1245 hours, an interview was conducted with the ADON. The ADON stated a fall was when the resident moved from one surface to another surface. The ADON was asked what the protocol was if a fall occurred. The ADON stated, if the fall was witnessed, the staff would inform the resident's nurse, the resident would be assessed for any injuries and if no abnormalities, and the resident would be transferred back to bed. The nurse would then inform the physician and family, and interview the resident to determine the cause. The ADON also stated the nurse would complete the change of condition and update the care plan. On 5/16/24at 1320 hours, a follow up interview and concurrent medical record review for Resident 8 was conducted with the ADON. The ADON provided the following measurements: - height of low bed: 10 inches - height of mattress on the ground: seven inches. The ADON stated Resident 8's bed and the mattress on the ground were not at the same level. The ADON further stated Resident 8 should have been assessed when found on the mattress and the incident should have been documented. The ADON verified there was no documentation, the physician was not notified, and a change of condition assessment was not completed for Resident 8's fall on 4/25/24. On 5/16/24 at 1635 hours, the ADON was informed and acknowledged the above findings. The ADON stated he would inform the DON. 2a. Closed medical record review for Resident 8 was initiated on 5/13/24. Resident 8 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 8's Progress Notes showed a Health Status Note dated 4/29/24 at 1434 hours. The note showed Resident 8 had an unwitnessed fall from his bed. Review of Resident 8's Neuro Check Flowsheet dated 4/29/24, showed the following documented assessments: * Every 15 minutes x 4: - Q 15min #1 dated 4/29/24 at 1314 hours: level of consciousness was not selected - Q 15min #2- dated 4/29/24 at 1329 hours: level of consciousness was not selected, pain response not selected - Q 15min #3- dated 4/29/24 at 1344 hours: pain response was not selected - Q 15min #4- dated 4/29/24 at 1359 hours: pain response was not selected * Every 30 minutes x 4: - Q 30 min #1 on 4/29/24 at 1429 hours: bilateral upper and lower extremities strength were not documented, pain response was not selected, and not signed by the nurse who completed the assessment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Q 30 min #2 on 4/29/24 at 1459 hours: most recent respirations not documented, pain response was not selected - Q 30 min #3 was not completed - Q 30 min #4 was not completed * Every one-hour x 4: - Q 1 hr. #1- dated 4/29/24 at 1559 hours: bilateral pupillary size and reaction were not documented, bilateral upper and lower extremities strength were not documented, pain response was not selected, pain response was not selected - Q1 hr. #2- dated 4/29/24 at 1659 hours: bilateral pupillary size and reaction were not documented, bilateral upper and lower extremities strength were not documented, pain response was not selected, pain response was not selected - Q1 hr. #3- dated 4/29/24at 1759 hours: bilateral pupillary size and reaction were not documented, bilateral upper and lower extremities strength were not documented, pain response was not selected, pain response was not selected - Q1 hr. #4- dated 4/29/24 at 1859 hours: bilateral pupillary size and reaction were not documented, bilateral upper and lower extremities strength were not documented, pain response was not selected, pain response was not selected On 5/ 15/24 at 1425 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated the neurological evaluations should have been complete for each monitoring interval. b. Medical record review for Resident 9 was initiated on 5/14/24. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 9's Order Summary Report dated 5/13/24, showed a physician's order dated 2/20/24, to apply floor mat every shift, for fall precaution. Review of Resident 9's plan of care showed a care plan problem dated 4/29/24, addressing Resident 9's actual fall with no injury. The interventions showed to continue interventions on the at-risk for fall care plan. Review of Resident 9's eInteract Change in Condition Evaluation dated 4/28/24, showed Resident 9 had an unwitnessed fall in her bedroom and was noted on the floor sitting next to her bed. Review of Resident 9's Neuro Check Flowsheet dated 4/28/24, showed the following documented assessments: * Every 15 minutes x 4: - Q 15 min #1- dated 4/28/24 at 2030 hours: all sections completed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Q 15 min #2- Is this assessment still needed? No was selected - Q 15 min #3- Is this assessment still needed? No was selected - Q 15 min #4- Is this assessment still needed? No was selected * Every 30 minutes x 4: for assessments 1-4: Is this assessment still needed? No was selected. * Every one-hour x 4: - Q 1 hr. #1- dated 4/29/24 at 0004 hours: respiration was not documented. * Every four hours x 4: - Q 4 hr. #1- dated 4/29/24 at 0700 hours: respirations were not documented. - Q 4 hr. #2- dated 4/29/24 at 1130 hours: respirations were not documented. - Q 4 hr. #3- dated 4/29/24 at 1500 hours: all sections completed, - Q 4 hr. #4- Is this assessment still needed? No was selected, * Every shift to complete 72 hours: - Q shift #1- is this assessment still needed? yes was selected, however sections 2 to 17 were left blank, - Q shift #2- dated 4/29/24 at 1715 hours: all sections completed, - Q shift #3- dated 4/30/24 at 0331 hours: all sections completed. - Q shift #4- dated 5/1/24 at 0700 hours: all sections completed (no assessment documented for 4/30/24 for the 0700-1500 shift and 1500 to 2300 shift) - Q shift #5- dated 5/1/24 at 1500 hours: all sections completed. On 5/14/24 at 1130 hours, an interview was conducted with the DON. The DON stated for any witnessed fall with head injuries, and for all unwitnessed falls, the resident would be assessed for injuries, a neuro check would be done for 72 hours, a Change of Condition assessment should be completed, and the physician and responsible party would be informed. The DON stated neuro checks are done following the Neuro Check Flowsheet: every 15 minutes x4, every 30 minutes x 4, every hour x 4, every four hours x 4, and then every shift to complete the 72-hour monitoring. The DON further stated she expected staff to complete neuro checks and document assessments accurately and completely for each monitoring interval to ensure any change of condition, as a result from the fall, would be detected timely. The DON stated potential risks for any unwitnessed falls that may occur would be injuries such as subdural hematomas which may occur over time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1135 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated the neurological evaluations should have been complete for each monitoring interval and the nurse should not have selected no when asked if the assessment was still needed. 3. Review of the facility's P&P titled Change in a Resident's Condition or Status undated showed the nurse will notify the resident's physician when there has been a significant change in the condition of a resident, which includes any status that does not resolve itself without intervention by staff. Closed medical record review for Resident 8 was initiated on 5/13/24. Resident 8 was admitted to the facility on [DATE] and discharged on [DATE]. Resident 8 had the diagnosis of bronchiectasis (a condition where the airways of the lungs become widened, leading to a build-up of excess mucus that can make the lungs more vulnerable to infection, most common symptoms are persistent cough with phlegm or shortness of breath). Review of Resident 8's Order Summary Report dated 5/13/24, showed the following physician's orders dated 4/19/24: - to monitor vital signs every shift for three days - to administer oxygen at two liters per min via nasal cannula as needed for diagnosis of shortness of breath or desaturation. Review of Resident 8's Admission Summary dated 4/19/24, showed nursing documentation Resident 8 was admitted with no respiratory distress noted, saturating well on room air. Review of Resident 8's MAR for April 2024 showed the following Oxygen saturation readings: - on 4/21/24, for the 0700 to 1500 shift, 87% - on 4/21/24, for the 1500 to 2300 shift, 87% - on 4/21/24, for the 2300 to 0700 shift, 87% Review of Resident 8's Progress Notes for April 2024 failed to show documentation Resident 8 was assessed, oxygen saturation levels were rechecked, or the physician and responsible party were notified on 4/21/24. Further review of the Progress Notes showed on 4/23/24 at 1450 hours, the nurse documented Resident 8 was given oxygen PRN due to overactive and agitated, oxygen was fluctuating between 90-92% on 2 liters and after oxygen level is at 99% on oxygen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1200 hours, an interview and concurrent closed medical record review for Resident 8 was conducted with the DON. When asked what the protocol was for a resident with low oxygen saturation reading, the DON stated she expected staff to assess the resident for any signs of distress and to recheck the oxygen saturation level. If the oxygen saturation level was normal, then the nurse should document the rechecked oxygen saturation reading. If the oxygen saturation level was low, she expected the nurse to administer oxygen and inform the physician and family. The DON verified the above oxygen saturation levels of 87% oxygen saturation were low on 4/21/24. The DON further verified there were no documentation in the progress notes that the oxygen saturation levels were rechecked, any interventions, or that the physician was informed. The DON verified and acknowledged the above findings. 4. Review of the facility's P&P titled Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol revised on 9/2017 showed the following: 2. Examples of lower gastrointestinal tract conditions and symptoms include: b. Fecal incontinence; f. Alteration in bowel movements; h. Residents taking antidiarrheal medications or medications related to bowel motility; and 3. In addition, the nurses shall assess and document/report the following: d. Presence of fecal impaction Review of the facility's P&P titled Charting and Documentation P&P undated showed all 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 P&P further showed the following: 2. The following information is to be documented in the resident medical record: c. Treatments or services performed; and 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. The signature and title of the individual documenting. Medical record review for Resident 4 was initiated on 5/15/24. Resident 4 was admitted to the facility on [DATE] and readmitted back to the facility on [DATE]. Review of Resident 4's medical records titled Quarterly MDS dated [DATE] showed Resident 4 with a BIMS score of 15 (according to the MDS RAI Manual, a score of 13-15 indicates resident is cognitively intact). On 5/16/24 at 0825 hours, an interview was conducted with Resident 4. Resident 4 stated she had an episode of constipation on 3/28/24 and requested for manual fecal disimpaction to assist with the removal of her stool. Resident 4 stated RN 1 performed the manual fecal disimpaction. Resident 4 stated when asked for documentation regarding the manual fecal disimpaction procedure by RN 1, Resident 4 stated the facility was unable to provide her the information. Review of Resident 4's medical records titled Orders Summary Report from March 2024 to May 2024 showed no documented evidence Resident 4 had a physician's orders for manual fecal disimpaction. Further review of Resident 4's Orders Summary Report for May 2024 showed Resident 4 was taking the following BM medications: - Docusate 250 mg orally twice daily ordered on 3/29/24. - Lactulose 10gm/15ml to give 30 mg orally every 24 hours PRN if no BM in three days ordered on 9/18/23. - Dulcolax rectal suppository 10 mg to give one suppository rectally every 24 hours PRN if no BM in 72 hours, give if lactulose is ineffective ordered on 9/15/23. Review of Resident's Progress Notes from March 2024 to May 2024 showed no documented evidence the facility nursing staff had contacted Resident 4's physician for a manual fecal disimpaction orders and no documented evidence a manual fecal disimpaction procedure was done. On 5/16/24 at 1145 hours, an interview with LVN 2 was conducted. LVN 2 stated manual fecal disimpaction were for residents with chronic constipation who needs assistance with passing stool. LVN 2 further stated the manual fecal disimpaction will require a physician's order and documentation. On 5/16/24 at 1438 hours, a telephone interview with RN 1 was conducted. RN 1 verified she did perform a manual fecal disimpaction for Resident 4. RN 1 was unable to give a date; however, stated she performed the manual fecal disimpaction for Resident 4 only once. RN 1 stated the manual fecal disimpaction requires a physician's order and documentation. RN 1 verified she should have notified Resident 4's physician to receive an order and documented the procedure. RN 1 stated she was not aware of Resident 4's PRN lactulose order and did not offer the medication to the resident. RN 1 further stated risks to performing a manual fecal disimpaction included bleeding and hitting the vagal nerves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056010	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 1600 hours, a concurrent interview and medical record review was conducted with the ADON. The ADON verified there was no documented evidence Resident 4's physician was paged for a manual fecal disimpaction order and no documentation the procedure was performed. The ADON further stated Resident 4 has PRN lactulose orders to assist with her BM and should have been offered before performing a manual fecal disimpaction. The ADON further stated the expectation of the license nurses were to receive physician's order for manual fecal disimpaction and document. 5. Review of Resident 4's Orders Summary Report for May 2024 showed the resident is on the following BM medications: - Docusate 250 mg orally twice daily ordered on 3/29/24; - Lactulose 10 gm/15 ml to give 30 mg orally every 24 hours PRN if no BM in three days ordered on 9/18/23; and - Dulcolax rectal suppository 10mg to give one suppository rectally every 24 hours PRN if no BM in 72 hours, give if lactulose is ineffective ordered on 9/15/23. Review of the facility's document titled Documentation Survey Report V2 for April 2024 showed Resident 4 did not have a BM from 4/15 to 4/20/24. Review of the facility document titled Documentation Survey Report V2 for May 2024 showed Resident 4 did not have a BM from 5/5 to 5/8/24. On 5/16/24 at 1118 hours, an interview was conducted with LVN 3. LVN 3 stated the charge nurses obtain a report at the beginning of their shift to identify the residents who are constipated and will need to be monitored for a BM. LVN 3 stated constipation is when a resident has not had a BM in over three days. On 5/16/24 at 1145 hours, an interview was conducted with LVN 2. LVN 2 stated nurses offer non-pharmalogical interventions for residents who are constipated and then offer PRN BM medications as ordered. LVN 2 further stated if the first PRN BM medication was ineffective, nurses would offer the next PRN BM medication ordered. On 5/16/24 at 1345 hours, a concurrent interview and record review was conductedwith the ADON. The ADON verified Resident 4 did not have a BM documented on 4/15 to 4/20/24 and 5/5 to 5/8/24. The ADON also verified Resident 4 did not receive PRN lactulose as ordered during these dates. The ADON stated 4/15 to 4/20/24 and 5/5 to 5/8/24 were greater than three days of no BM and Resident 4 should have received the PRN lactulose as ordered for no BM in three days. The ADON further stated the expectation of the nurses were to offer PRN BM medications as ordered for no BM greater than three days and to notify the resident's physician if PRN BM medications were ineffective for further orders. On 5/16/24 at 1635 hours, an interview with the ADON was conducted. The ADON verified and acknowledged all the above findings. The ADON stated he would inform the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056010	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Beach Health and Rehabilitation Center	3000 N Gate Road Seal Beach, CA 90740

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, and medical record review, the facility failed to ensure one of two sampled residents (Resident 9) remained free from accident hazards. * The facility failed to implement the floor mats as per the physician's order and resident's plan of care. This failure had the potential to place the resident at risk for serious injury. Findings: On 5/14/24 at 0855 hours, Resident 9 was observed in bed, with the head of bed elevated. No floor mats were observed. Medical record review for Resident 9 was initiated on 5/14/24. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's Order Summary Report dated 5/13/24, showed a physician's order dated 2/20/24, to apply the floor mats every shift for fall precautions. Review of Resident 9's plan of care showed the care plan problem dated 4/29/24, addressing Resident 9 ' s actual fall with no injury. The interventions showed to continue the interventions on the at-risk for fall care plan. Further review of Resident 9 ' s plan of care, showed a care plan problem dated 10/28/22, addressing Resident 9 ' s risk for fall related to lack of safety awareness, history of falls, and cognitive deficit. The interventions for bed and surrounding modifications showed to have floor mat in place. On 5/14/24 at 0918 hours, Resident 9 was observed in bed with no floor mats. On 5/14/24 at 1105 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 1. LVN 1 verified the above findings. On 5/14/24 at 1120 hours, an observation and concurrent interview was conducted with LVN 1 in Resident 9's room. Resident 9 was observed sitting in a wheelchair. LVN 1 verified Resident 9 did not have floor mats as per the physician's order and the resident's plan of care. LVN 1 stated there were no other floor mats in the room other than the mats observed beside Resident 9's roommate's bed. On 5/14/24 at 1130 hours an interview was conducted with the DON. The DON stated she expected staff to carry out orders made by the physician. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 8) was free from the unnecessary drugs. * The licensed nurses administered midodrine (medication for blood pressure support) outside of the physician's ordered parameters. This failure had the potential for the resident to experience adverse side effects that could affect the resident's well-being. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in accordance with prescriber orders, including any required time frame. The following information is checked/verified for each resident prior to administering medications: allergies to medications and vital signs, if necessary. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication. Closed medical record review for Resident 8 was initiated on 5/13/24. Resident 8 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 8's Order Summary Report dated 5/13/24, showed a physician's order dated 4/19/24, to administer midodrine hcl 5 mg one tablet by mouth three times a day for hypotension andto hold if SBP greater than 130 mmHg. Review of Resident 8's MAR for April 2024 showed Resident 8 was administered midodrine 5 mg one tablet by mouth on the following days with the following BP results: - on 4/26/24 at 1400 hours, BP was 131/80 mmHg and - on 4/27/24 at 2000 hours, BP 132/78 mmHg. On 5/14/24 at 0805 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 7. LVN 7 verified the above findings, and stated the above medication should have been held as ordered by the physician. On 5/14/24 at 1210 hours, the DON was informed and acknowledged the above findings. The DON stated the above doses should not have been administered with the ordered p