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	06/21/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 1) was informed of the dosage changes for their psychotropic medications. * The facility failed to ensure Resident 1 was informed of the decrease in dosage of amitriptyline (antidepressant medication) and sertraline (antidepressant medication). * The facility failed to ensure Resident 1's informed consent was obtained prior to administering the increase in dosage of amitriptyline and sertraline. These failures had the potential for Resident 1 not be informed of the medications and their potential side effects. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated July 2022 showed Residents are involved in the medication management process. Psychotropic medication management includes indications for use and dose. Medical record review for Resident 1 was initiated on 5/29/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 2/17/23, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Order Summary Report for May 2024 showed the following orders: - dated 4/14/24, for amitriptyline HCl oral tablet 25 mg one tablet by mouth at bedtime for depression, and to verify the informed consent obtained by the MD from the resident/RP after the explanation of the risks and benefits. - dated 4/14/24, for sertraline HCl oral tablet 75 mg one tablet by mouth one time a day for depression and to verify the informed consent obtained by the MD from the resident/RP after the explanation of the risks and benefits. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Order Summary Report for June 2024 showed the following orders: - dated 6/5/24, for amitriptyline HCl oral tablet 25 mg two tablets by mouth at bedtime for depression and to verify the informed consent obtained by the MD from the resident/RP after the explanation of the risks and benefits. - dated 6/5/24, for sertraline HCl oral tablet 100 mg one tablet by mouth one time a day for depression and to verify the informed consent obtained by the MD from the resident/RP after the explanation of the risks and benefits. Further review of Resident 1's medical record failed to show documented evidence the facility verified an informed consent was obtained for the increased dosages of the above medications as follows: - two oral tablets of amitriptyline 25 mg, an increase of one tablet from the order dated 4/14/24. - one tablet of sertraline 100 mg, an increase of 25 mg from the order dated 4/14/24. On 6/20/24 at 1000 hours, a concurrent interview and medical record review was conducted with the QA Nurse. The QA Nurse verified the above findings. The QA Nurse verified Resident 1 was receiving amitriptyline 25 mg two tablets by mouth at bedtime for depression and sertraline 100 mg one tablet by mouth one time a day for depression. The QA Nurse verified the informed consents for amitriptyline and sertraline were not obtained from Resident 1 prior to administration of the medications. On 6/20/24 at 1530 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 1 was not informed of the GDR attempts and the informed consents for amitriptyline and sertraline were not obtained from Resident 1 prior to the administration of the medications.

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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 0553 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of two sampled residents (Residents 1 and 2) were invited to the interdisciplinary team behavior management conference. This failure had the potential for the residents to not be able to participate in choosing their treatment options and making decisions in care planning. Findings: Review of the facility's P&P titled Care Planning - Interdisciplinary Team dated March 2022 showed the resident is encouraged to participate in the development of and revisions to the resident's care plan. 1. Medical record review for Resident 1 was initiated on 5/29/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 2/17/23, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's IDT Behavior Management forms dated 12/7/23 and 2/22/24, showed the following attendees: - Nursing - Activities - Social Services - Psychiatrist/Psychologist Further review of Resident 1's medical record failed to show documented evidence Resident 1 was encouraged to participate in the IDT care conferences. On 5/29/24 at 1250 hours, a concurrent interview and medical record review was conducted with the ADON. The ADON acknowledged and verified Resident 1 did not participate in the IDT meetings. The ADON stated Resident 1 should have been encouraged to participate in the IDT meetings. 2. Medical record review for Resident 2 was initiated on 6/20/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident 2 had no cognitive impairment. Review of Resident 1's IDT Behavior Management forms dated 1/11/24 and 4/4/24, showed the following attendees: (continued on next page)

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F 0553 Level of Harm - Potential for minimal harm Residents Affected - Some	- Nursing - Activities - Social Services - Psychiatrist/Psychologist Further review of Resident 2's medical record failed to show documented evidence Resident 2 was encouraged to participate in the IDT care conferences. On 6/20/24 at 1530 hours, a concurrent interview and medical record review was conducted with the DON. The DON acknowledged and verified Resident 2 did not participate in the IDT meetings. The DON stated Resident 2 should have been encouraged to participate in the IDT meetings.

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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 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40617 Based observation and interview, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment. * The licensed nurse placed the personal belongings on top of the treatment cart. * Resident 3's nasal cannula was observed on the floor. These failures had the potential for cross contamination and promote the development of transmission of diseases and infection. Findings: 1. On 6/20/24 at 1117 hours, a black jacket was observed hanging on the side of the treatment cart and a bottle of water was placed next to a saline spray bottle on the top of the treatment cart. On 6/20/24 at 955 hours, a concurrent observation and interview was conducted with the Treatment Nurse 1. Treatment Nurse 1 confirmed those items were her belongings and stated, I was never told not to have our stuff on the treatment cart. On 6/21/24 at 1045 hours, an interview conducted with the DON. The DON acknowledged the finding and further stated that there should be no personal belongings on the treatment cart for infection control measures. Upon requesting for aP&P on infection control, the DON was unable to provide one related to the specific finding. 2. On 5/29/24 at 1320 hours, an observation was conducted of Resident 3. Resident 3 was observed lying in bed. Resident 3's nasal cannula was observed on the floor. On 5/29/24 at 1325 hours, a concurrent observation and interview was conducted with LVN 1. Resident 3's nasal cannula was observed lying on the floor. LVN 1 verified the findings and stated Resident 3's nasal cannula needed to be stored in a clean bag for infection control and not on the floor.