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	10/24/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development and worsening of pressure injuries for two of six sampled residents (Residents 2 and 3). * The facility failed to complete the discharge skin assessment for Resident 2's coccyx Stage 2 pressure injury. * The facility failed to ensure Resident 3's low air loss mattress was plugged in for Resident 3 who had an unstageable pressure injury to the sacrum. These failures had the potential for not providing the necessary care and services for Residents 2 and 3. Findings: Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown Clinical Protocol revised 4/2018 showed the nurse shall document and report the following including current treatments, including support surfaces. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. Review of the facility's P&P titled Prevention of Pressure Injuries revised 4/2020 showed support surfaces and pressure redistribution: select appropriate surfaces based on the resident's risk factors, in accordance with currently clinical practice. 1. Closed medical record review for Resident 2 was initiated on 10/17/24. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Resident 2 had developed a Stage 2 pressure injury on 9/23/24. Review of Resident 2's H&P examination dated 9/13/24, showed Resident 2 did not have the capacity to make medical decisions. Review of Resident 2's eInteract Change in Condition Evaluation V5.1 dated 9/23/24, showed a new change in condition for the Stage 2 pressure injury located on the coccyx. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Skin and Wound Evaluation 7.0 dated 9/30/24, showed Resident 2 had the Stage 2 pressure injury located on the sacrum, measuring 3.5 cm (length) x 2.6 cm (width). Review of Resident 2's Discharge Instruction Form/Recapitulation of Stay V2 skin assessment was blank. On 10/23/24 at 1107 hours, a concurrent interview and closed medical record review for Resident 2 was conducted with LVN 3. LVN 3 verified Resident 2's discharge skin assessment was blank, and nothing was filled out for the skin assessment. On 10/23/24 at 1242 hours, a concurrent interview and closed medical record review for Resident 2 was conducted with RN 3. When asked if there was a discharge skin assessment for Resident 2, RN 3 stated it should be there. When asked if the discharge skin assessment was there, RN 3 stated no. On 10/24/24 at 0917 hours, a concurrent interview and closed medical record review for Resident 2 was conducted with LVN 6. LVN 6 verified the discharge skin assessment for Resident 2 was blank. When asked if there was documentation showing Resident 2's skin was assessed upon discharge, LVN 6 stated no. LVN 6 stated Resident 2's last skin assessment was documented on 9/30/24. When asked what Resident 2's coccyx wound stage was on 9/30/24, LVN 6 stated Stage 2. 2. Medical record review for Resident 3 was initiated on 10/17/24. Resident 3 was admitted to the facility 9/13/24, and readmitted on [DATE]. Resident 3 had an unstageable pressure injury on her sacrum. Review of Resident 3's Care Plan dated 9/16/24, showed a care plan intervention to use the pressure relieving device (low air loss mattress). On 10/17/24 at 1230 hours, an observation was conducted with CNA 4 in Resident 3's room. Resident 3 had a low air loss mattress device located at the foot of the bed. CNA 4 verified the device was unplugged and proceeded to plug the device into the outlet. On 10/24/24 at 1432 hours, an interview was conducted with the DSD. The DSD stated if the low air loss mattress was not turned on as there was no light indicator on the device. The DSD stated the low air loss mattress devices in the facility did not have a backup battery and would not function if it was not plugged in. On 10/24/24 at 1640 hours, the Administrator and ADON 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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical information was complete and accurate for one of six sampled residents (Resident 2). This failure had the potential to Resident 2 to receive inadequate care as the clinical information was not available. Findings: Review of the facility's P&P titled Charting and Documentation (undated) showed the following information is to be documented in the resident medical record-treatments or services performed. Documentation in the medical record will be objective (not opinionated, or speculative), complete, and accurate. Closed medical record review for Resident 2 was initiated on 10/17/24. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. a. Review of Resident 2's Care Plan dated 9/13/24, showed a care plan for pressure ulcer/skin injury related to impaired mobility and urinary/bowel incontinence. The interventions included to turn and reposition every two hours and as needed, and if incontinent, to check every two hours for soiling, or wetness, thoroughly cleanse after each episode of incontinence. Review of Resident 2's Documentation Survey V2 for September 2024 showed the following: - From 9/14-9/18/24, for bladder incontinence, all shifts were marked with an x indicating incomplete documentation. - From 9/14-9/18/24, for bowel incontinence, all shifts were marked with an x indicating incomplete documentation. - On 10/5/24, for turning and repositioning every two hours and as tolerated, it was marked with an x indicating incomplete documentation from 1500-2200 hours. b. Review of Resident 2's Physicians Order Summary Report dated 9/13/24 showed the following orders: - Foley catheter care every shift - Foley catheter, FR # 16/10 cc to BSD Review of Resident 2's Progress Notes dated 9/26/24, showed Resident 2's Foley catheter was removed. Review of Resident 2's Progress Notes dated 9/29/24, showed there was no Foley catheter in place. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 2's TAR showed the staff' initials indicating the task was completed on the following dates: - From 9/27-9/30/24, and 10/2-10/5/24, for Foley catheter, FR # 16/10 cc to BSD - From 9/27-9/28/24, 9/30/24, and 10/2-10/5/24, for Foley catheter care every shift On 10/24/24 at 1330 hours, a concurrent interview and closed medical record review was conducted with the ADON. When asked what x or blank meant in Resident 2's bladder and bowel incontinence documents, the ADON stated it meant incomplete documentation. On 10/24/24 at 1432 hours, a concurrent interview and closed medical record review was conducted with the DSD. The DSD stated if there were initials shown in the TAR indicating the task was done, and no initials indicated the task was not done. On 10/24/24 at 1640 hours, the Administrator and ADON acknowledged the above findings.

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F 0919 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 49348 Based on observation, interview, and facility P&P review, the facility failed to ensure the call light was within reach for Resident 5. This failure had the potential for the delayed provision of assistance to Resident 5. Findings: Review of the facility's P&P titled Answering the Call Light revised 9/2022 showed to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower, or bathing facility and from the floor; and to answer the resident call system immediately. On 10/17/24 at 0912 hours, a concurrent observation and interview was conducted with CNA 5 in Resident 5's room. Resident 5 was calling for help. Resident 5's call light was observed on top of the pillow and not within reach. CNA 5 verified the call light was not within reach of the resident. On 10/24/24 at 1640 hours, the Administrator and ADON acknowledged the above findings.