Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	02/19/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 12 sampled residents (Resident 1) was free from abuse. * Dietary Aide 1 yelled, cursed, and made derogatory comments to Resident 1. This failure negatively impacted Resident 1's emotional wellbeing and posed the risk of Resident 1 suffering physical symptoms from verbal abuse.Findings: Review of the facility's P&P titled Abuse Prevention Program (undated) showed the residents have the right to be free from abuse. Medical record review for Resident 1 was initiated on 2/10/26. Resident 1 was admitted to the facility on [DATE], with diagnoses including anxiety disorder and depression. Review of Resident 1's H&P examination dated 7/29/25, showed Resident 1 had normal cognition and was alert and oriented. Further review of the H&P examination showed Resident 1 expressed increased anxiety about having another heart attack. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of the facility's SOC 341 dated 2/8/26, showed Dietary Aide 1 was observed yelling at Resident 1 at approximately 1830 hours. Review of Resident 1's Change in Condition Evaluation dated 2/8/26 at 1845 hours, showed the resident was having increased anxiety related to the altercation with Dietary Aide 1. Further review of the Change in Condition Evaluation showed Resident 1 experienced brief situational emotional distress related to the meal service and returned to baseline with reassurance. Review of the facility's conclusion dated 2/13/26, showed on 2/8/26 at approximately 1800 hours, Resident 1 walked back to the kitchen because the meal tray she had received was not to her liking, and so the kitchen staff prepared a new meal tray for her. Dietary Aide 1 carried Resident 1's newly prepared meal tray and walked back to Resident 1's room with the resident. When Resident 1 and Dietary Aide 1 were walking back to her room, the facility staff overheard them talking loudly to each other, and heard Resident 1 call Dietary Aide 1 names. When Dietary Aide 1 returned to Resident 1's room to bring Resident 1 some yogurt, Resident 1 yelled at Dietary Aide 1 and Dietary Aide 1 responded by cursing at Resident 1. The facility's conclusion further showed a staff member should not respond with profanity towards a resident regardless of how a resident behaved. On 2/10/26 at 1137 hours, an interview was conducted with CNA 1. CNA 1 stated she overheard Dietary Aide 1 yell curse words at Resident 1 during meal pass on 2/8/26. On 2/10/26 at 1340 hours, an interview was conducted with CNA 2. CNA 2 stated during meal pass on 2/8/26, she overheard Dietary Aide 1 curse at Resident 1 and call her crazy. CNA 2 stated Resident 1 was crying and did not understand why Dietary Aide 1 acted that way. On 2/19/26 at 1800 hours, an interview was conducted with the DON. The DON verified the above findings.

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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(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** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary services and interventions to maintain the highest practicable well-being for one of 12 sampled residents (Resident 1). * The facility failed to conduct all of the required nursing assessments and monitoring on Resident 1, following a change of condition involving verbal abuse. This failure posed the risk of changes in Resident 1's emotional and physical well-being not being identified and potentially delayed the necessary care and treatment for the resident.Findings: Review of the facility's P&P titled Abuse and Neglect - Clinical Protocol, undated, showed the staff and physician will monitor individuals who have been abused to address any issues regarding their medical condition, mood, and function. Medical record review for Resident 1 was initiated on 2/10/26. Resident 1 was admitted to the facility on [DATE], with diagnoses including anxiety disorder and depression. Review of Resident 1's H&P examination dated 7/29/25, showed Resident 1 had normal cognition and was alert and oriented. Further review of the H&P examination showed Resident 1 expressed increased anxiety about having another heart attack. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of the facility's SOC 341 dated 2/8/26, showed Dietary Aide 1 was observed yelling at Resident 1 at approximately 1830 hours. Review of Resident 1's Change in Condition Evaluation dated 2/8/26 at 1845 hours, showed the resident was having increased anxiety related to the altercation with Dietary Aide 1. Further review of the Change in Condition Evaluation showed Resident 1 experienced brief situational emotional distress related to the meal service and returned to baseline with reassurance. Review of Resident 1's plan of care showed a care plan problem dated 2/8/26, addressing the resident's incident of verbal abuse. The interventions included monitoring Resident 1 for 72 hours for changes in routine and symptoms of distress. On 2/19/26 at 1125 hours, an interview was conducted with LVN 4. LVN 4 stated after a change in condition, the resident was to be monitored by the nursing staff every shift for 72 hours. LVN 4 stated the purpose of the monitoring was to focus on the condition to make sure the residents were receiving the proper interventions and to notify the physician to receive new orders if necessary. On 2/19/26 at 1155 hours, an interview and concurrent medical record review for Resident 1 was conducted with ADON 2. ADON 2 stated following a resident change in condition, the nursing staff was supposed to assess and monitor the resident every shift for 72 hours, with a focus on the change in condition. ADON 2 stated the purpose of the follow up assessments was to ensure the resident was not having any worsening symptoms or poor outcomes from the change in condition and to treat accordingly. ADON 2 stated if the assessments were not done, something could be missed and go untreated. ADON 2 stated the purpose of the follow up assessments for Resident 1 was to make sure Resident 1 was feeling safe and comfortable in the facility, and to assess for any pain. ADON 2 verified Resident 1 was not monitored following the verbal abuse allegation on the morning of 2/10/26, and all the assessments were missed on 2/11/26. On 2/19/26 at 1800 hours, an interview was conducted with the DON. The DON verified the above findings. Cross Reference to F600.