STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Cliff Healthcare Center	18811 Florida St Huntington Beach, CA 92648

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 provide the necessary care and services to one of two sampled residents (Resident 1) as ordered by the physician. * The facility failed to order and administerResident 1's aspirin (a medication used to thin the blood) and atorvastatin (a medication to treat high cholesterol) according to the discharge medication orders from the hospital. This failure had the potential to negatively affect the residents' health condition and well-being. Findings: Review of the facility's P&P titled Medication Orders (undated) showed under the section for Written Transfers Orders (sent with the resident by an acute care hospital or other health care facility) the following: - implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete or the date is different from the date of admission; - if the order is unsigned, signed by another prescriber, or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician before medications are administered; and - the nurse documents verification by entering the time, date, and signature on the admission order. Medical record review for Resident 1 was initiated on 4/26/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of CVA, pneumonia, and potential stroke. Review of Resident 1's Patient Discharge Instructions from the acute care hospital dated 4/26/24, showed a physician's order to administer the following new medications: - aspirin 81 mg enteric coated tablet, give one tablet by mouth daily; and - atorvastatin 40 mg oral tablet, give one tablet by mouth daily. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of Resident 1's Order Summary Report dated 5/1/24, did not show the orders to administer the aspirin and atorvastatin medications. Review of Resident 1's MARs for April and May 2024 showed no documented evidence of Resident 1 receiving the ordered aspirin and atorvastatin medications according to the discharge instructions from the acute care hospital. On 5/10/24 at 0836 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the aspirin and atorvastatin were the new prescribed medications for Resident 1 according to the acute care hospital's discharge orders. The LVN verified the medication orders were not followed through or carried out upon Resident 1's readmission to the facility. LVN 3 further stated the aspirin and atorvastatin were the medications that should have been carried out for the residents that had a diagnosis ofCVA. LVN 3 stated if the facility's physician did not agree with the new orders, it should have been documented. LVN 3 verified there was no documentation to show the facility's physician was notified of thenew medications. On 5/10/24 at 0927 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the admitting nurse was responsible for reconciling the final medication ordersfrom the acute care hospital's discharge medication list. The DON further stated the nurse did not see the new orders. The DON acknowledged the above findings.