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	10/22/2025

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 ensure the comprehensive plan of care for one of eight sampled residents (Resident 4) was revised to reflect the resident's current care needs and interventions. * The facility failed to ensure Resident 4's plan of care for swallowing problem was reviewed and revised to address Resident 4's difficulty in swallowing the medication and coughing with sips of water. This failure posed the risk of not providing appropriate, consistent, and individualized care to the resident.Findings: Review of the facility's P&P titled Change of Condition revised 5/2019 showed to document the resident change of condition and response in eInteract Change of Condition and in the nursing progress notes, and update resident care plan, as indicated. Closed medical record review for Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 4's H&P examination dated [DATE], showed Resident 4 had capacity to understand and make decisions. Review of Resident 4's admission MDS assessment dated [DATE], showed Resident 4's BIMS score was three, indicating severe cognitive impairment. Review of Resident 4's eInteract Change in Condition Evaluation dated [DATE] at 1030 hours, showed the resident was observed to have coughed after the first sip of water when the whole medication tablet was administered. The medications were then crushed. Review of Resident 4's plan of care failed to show the care plan problem addressing the resident's swallowing problem was reviewed and revised to reflect the resident's change in the condition on [DATE], when the resident had difficulty swallowing the medication and coughing with the sips of water. On [DATE] at 1430 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the above findings and stated Resident 4's care plan should have been revised. Cross reference to F684.

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. (continued on next page)

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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	**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 care and services to attain or maintain the highest practicable well-being for one of eight sampled residents (Resident 4). * The facility failed to assess and monitor Resident 4's condition after the resident had difficulty swallowing his morning medications on [DATE]. In addition, the facility failed to administer the warfarin sodium (blood thinner) to Resident 4 daily as ordered by the physician on [DATE]. These failures had the potential to negatively impact the resident's well-being.Findings: Closed medical record review for Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 4's H&P dated [DATE], showed resident had capacity to understand and make decisions. Review of Resident 4's admission MDS assessment dated [DATE], showed Resident 4's BIMS score was three, indicating severe cognitive impairment. Review of Resident 4's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for regular diet - Level 7 texture with thin liquid (Level 0 consistency). a. Review of the facility's P&P titled Change of Condition revised 5/2019 showed any change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician. Document the resident's change of condition and response in eInteract Change of Condition and in the nursing progress notes, and update resident care plan, as indicated. The licensed nurse responsible for the resident will continue assessment and documentation every shift for at least seventy-two (72) hours or until condition has stabled. Review of Resident 4's eInteract Change in Condition Evaluation dated [DATE] at 1030 hours, showed the resident was observed to have coughed after the first sip of water when the whole medication tablet was administered. The medications were then crushed. Review of Resident 4's nursing progress notes dated [DATE] at 1930 hours, showed the resident was observed unresponsive with light pulse, and no respirations noted. Further review of Resident 4's nursing progress notes dated [DATE] at 1939 hours, showed the resident had no vital signs. Review of Resident 4's Documentation Survey Report v2 - Intervention/ Task - Amount Eaten failed to show the meal percentages consumed by the resident on [DATE], for breakfast, lunch, and dinner. Review of Resident 4's plan of care failed to show the care plan problem addressing the resident's swallowing problem was reviewed and revised to reflect the resident's change in the condition on [DATE], when the resident had difficulty swallowing the medication and coughing with the sips of water. Further review of Resident 4's closed medical record failed to show documented evidence the resident was monitored, and provided with care and safety measures after the resident was observed to have coughed after the first sip of water when the whole medication tablet was administered on [DATE] at 1030 hours. On [DATE] at 1020 hours, a telephone interview was conducted with LVN 4. LVN 4 stated Resident 4 started coughing when she administered with the first whole pill for the morning of [DATE]. LVN 4 further stated the resident started chocking with the water. LVN 4 stated she then crushed the resident's medications and informed the ST of the resident's change in condition. LVN 4 stated Resident 4 would be evaluated by the ST the following day. On [DATE] at 1122 hours, an interview with ST 1 was conducted. ST 1 stated Resident 4 was on speech therapy and tolerating the baseline diet and regular thin liquids. ST 1 further stated Resident 4 was last seen on [DATE], with no changes in condition. On [DATE] at 1135 hours, an interview was conducted with ST 2. ST 2 stated LVN 4 informed him Resident 4 had difficulty swallowing the pills on [DATE]. ST 2 stated Resident 4 was placed on the schedule to be seen by ST 1 the following day. On [DATE] at 1158 hours, an interview was conducted with CNA 1. CNA 1 stated she assisted Resident 4 with breakfast and lunch and stated Resident 4 ate slowly. CNA 1 verified she failed to document Resident 4's meal intakes on the resident's Documentation Survey Report v2 - Intervention/ Task - Amount Eaten. On [DATE] at 1430 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 4's closed medical record failed to show documented evidence the resident was monitored and provided with care and safety measures after the resident had a change in condition in the morning of [DATE]. The DON stated the resident was scheduled to be seen by ST the following day. The DON stated she expected the licensed nurses and ST to reassess Resident 4's change of condition. b. Review of the facility's P&P titled Physician Orders revised 5/2007 showed the drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to assure that refills are on hand. Review of Resident 4's Order Summary Report dated

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 pharmaceutical services for one of eight sampled residents (Resident 4) when: * LVN 4 crushed Resident 4's iron (supplement) tablet and administered it to the resident. This failure had the potential to negatively affect the resident's health conditions and posed the risk for possible complications. Findings: Review of the facility's P&P titled Crushing Medications (undated) showed the nursing staff will crush only medications that may be crushed. The Nursing Staff will use available references and resources to determine which medications should and should not be crushed. According to National Library of Medicine Daily Med:- Iron tablets are enteric coated (coating applied to oral medications to prevent the medications from dissolving in the highly acidic stomach environment) and should not be chewed or crushed. Iron tablets are enteric coated to help protect the stomach. Iron may cause gastrointestinal discomfort, nausea, constipation or diarrhea. - Tamsulosin hydrochloride (used to treat enlarged prostate) capsules should not be crushed, chewed or opened. The capsules contain a special modified-release formulation, typically sustained-release beads, that controls how the medicine is absorbed by your body. Opening the capsule can disrupt this mechanism and potentially cause serious side effects. Retrieved from https://dailymed.nlm.nih.gov/dailymed/drugInfo. Closed medical record review for Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 4's H&P examination dated [DATE], showed the resident had capacity to understand and make decisions. Review of Resident 4's admission MDS assessment dated [DATE], showed Resident 4's BIMS score was three, indicating severe cognitive impairment. Review of Resident 4's eInteract Change in Condition Evaluation dated [DATE] at 1030 hours, showed the resident was observed to have coughed after the first sip of water when the whole medication tablet was administered. The medications were then crushed. Review of Resident 4's Order Summary Report dated [DATE], showed the following physician's orders:- dated [DATE], to administer iron 25 mg one tablet by mouth one time a day; and- dated [DATE], to administer tamsulosin hydrochloride 0.4 mg one capsule by mouth every 12 hours. Review of Resident 4's MAR for [DATE] showed the iron 25 mg and tamsulosin hydrochloride 0.4 mg medications were administered to Resident 4 on [DATE] at 0900 hours. On [DATE] at 1020 hours, a telephone interview was conducted with LVN 4. LVN 4 stated Resident 4 started coughing when she first administered the whole pill on the morning of [DATE]. LVN 4 further stated the resident started chocking with the water. LVN 4 stated she then crushed all the resident's medications to be able to administer them to the resident. On [DATE] at 1520 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.