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	01/14/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop a care plan and implement care plan interventions for four of 33 final sampled residents (Residents 42, 95, and 161) and one of three closed record sampled residents (Resident 83). * The facility failed to implement Resident 42 and 95's care plan intervention to monitor the residents' safety for entrapment every shift. * The facility failed to develop a care plan to address Resident 83's intergluteal cleft extending to perianal (describes the natural groove between the buttocks that reaches the anus) MASD (Moisture-Associated Skin Damage, skin inflammation or erosion from prolonged exposure to moisture like urine, feces, sweat, or wound drainage, weakening the skin's barrier and making it vulnerable to irritation, infection, friction, and breakdown). * The facility failed to develop a care plan to address Resident 161's left upper arm midline catheter. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents.Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised April 2025 showed it is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. 1.a. Medical record review for Resident 42 was initiated on 1/6/26. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's care plan for risk for entrapment/bodily injury secondary to but not limited by bilateral 1/2 (half) siderails initiated 8/24/23, showed the interventions included to monitor the resident's safety for entrapment for the use of the bedrails to aid bed mobility every shift. Review of Resident 42's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 42's medical record failed to show documented evidence the resident was monitored for safety for entrapment for the bedrail use. On 1/13/26 at 1357 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 42's care plan intervention to monitor resident's safety for entrapment (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: 555249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	for the use of the bedrails to aid bed mobility every shift was not implemented. LVN 3 stated the licensed nurse should have documented the monitoring of Resident 42 in the MAR or progress note. b. Medical record review for Resident 95 was initiated on 1/6/26. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's care plan for risk for entrapment/bodily injury secondary to but not limited by the use of the bariatric bed with built in bilateral 1/2 siderails initiated 5/13/22, showed the interventions included to monitor the resident's safety for entrapment for the use of the bedrails to aid bed mobility every shift. Review of Resident 95's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 95's medical record failed to show documented evidence the resident was monitored for safety for entrapment for the bedrail use. On 1/13/26 at 1416 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 95's care plan intervention to monitor resident's safety for entrapment for the use of the bedrails to aid in bed mobility every shift was not implemented. LVN 3 stated Resident 95 should have been monitored every shift as indicated in the care plan. On 1/14/26 at 1043 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Closed medical record review for Resident 83 was initiated on 1/9/25. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed an order dated 12/12/25, to cleanse intergluteal cleft extending to perianal MASD with soap and water, pat dry and apply barrier cream every day shift. Review of Resident 83's medical record failed to show a care plan was developed to address Resident 83's intergluteal cleft extending to perianal MASD. On 1/14/26 at 1040 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 4. RN 4 verified there was no care plan developed for Resident 83's intergluteal cleft extending to perianal MASD. On 1/14/26 at 1435 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 1/6/26 at 1418 hours, during the initial tour of the facility, Resident 161 was observed in bed with an IV access on her left upper arm. Medical record review for Resident 161 was initiated on 1/6/26. Resident 161 was readmitted to the facility on [DATE]. Review of Resident 161's Nursing Progress Note dated 12/30/25, showed Resident 161 had a midline IV access on the left upper arm. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident 161's plan of care showed a care plan initiated 12/30/25, for Resident 161's IV medication and midline catheter on the right upper arm, instead of the left upper arm. On 1/8/26 at 1500 hours, an interview and concurrent medical record review for Resident 161 was conducted with RN 1. RN 1 verified Resident 161 had midline IV access on the left upper arm. RN 1 also verified the care plan for midline catheter was for the right upper arm, instead of the left upper arm. On 1/14/26 at 1444 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed and verified the above findings.