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	09/06/2024

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 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** 49324 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to protect the residents' rights to be free from the physical abuse for two of six sampled residents (Residents 1 and 2). * Resident 2 allegedly called Resident 1 a bad word and scratched Resident 1's face. In response, Resident 1 bit Resident 2's hand and was found by staff with Resident 2's hand in her mouth. Resident 1 had a scratch mark on her face and Resident 2 had a bite mark on her right hand. This failure had the potential for Residents 1 and 2 to be seriously injured or have psychosocial harm. Findings: Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against revised on 1/2021 showed in part, it is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation .E. Identification. 2. Because some cases of abuse are not directly observed, understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include, but are not limited to: - Bruises, skin tears and injuries of unknown source; - Extensive injuries; - Injuries in an unusual location; - Occurrences, patterns, and trends that may constitute abuse; - Episodes of resident-to-resident altercation, willful or accidental, with or without injury. - Sudden or unexplained changes in behaviors or activities (e.g., fear of a person or place, feelings of guilt or shame, etc.). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Resident Rights, source Federal Register amended 7/13/17, showed as a resident of this nursing facility, a resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A resident has the right to exercise their rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as citizen or resident of the United States. A resident has a right to be treated with respect and dignity, including the right to a resident have a right to safe, clean, comfortable and homelike environment, and use of your personal belongings to the extent possible, including but not limited to receiving treatment and supports for daily living safely. Review of the facility's SOC 341 dated 8/29/24, showed at around 1430 hours, the staff observed Resident 1 sitting in her wheelchair next to Resident 2's bed. Resident 2's hand was noted in Resident 1's mouth. Resident 1 stated she bit Resident 2's hand out of self-defense because Resident 2 had called her bitch and scratched her face. The residents were immediately separated. Resident 1 was assessed and noted with a scratch to the right side of her face. Resident 2 was assessed and noted with a bite mark to her right hand. Review of the facility's Summary of Investigation letter dated 8/30/24, showed two employees heard noises coming from the residents' room. The staff observed Resident 1 had Resident 2's hand in her mouth. Resident 1 stated Resident 2 called her a derogatory name and scratched the right side of her face. In self-defense, Resident 1 bit Resident 2's hand. Resident 1 was assessed and noted with a scratch mark to the right side of her face. Resident 2 stated Resident 1 bit her. Resident 2 further stated she started it and stated she should have just stayed quiet. Resident 2 stated Resident 1 was being too loud and she told Resident 1 to keep it down. Resident 2 stated Resident 1 got mad and then they started arguing. Resident 2 was assessed and noted with a bite mark to her right hand. The facility substantiated the allegation of abuse between Residents 1 and 2. a. Medical record review for Resident 1 was initiated on 9/4/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS Section C dated 7/3/24, showed Resident 1 had a BIMS score of 12, indicating moderate cognitive impairment. Review of Resident 1's Nurse Progress Note dated 8/29/24 at 1523 hours, showed Resident 1 found in a sitting position in her wheelchair. Resident 1 stated Resident 2 scratched the right side of her face. Scratch marks were noted on the resident's right side of face. Resident 1 stated in self-defense, she bit Resident 2's hand. Review of Resident 1's Skin Evaluation- PRN/Weekly dated 8/29/24, showed Resident 1 was status post alleged altercation with another resident. Upon visualization, Resident 1 was noted to have dried diffused scratches around the right side of the face extending to the neck. No fresh bleeding was found, no redness. Scabbing noted upon assessment. The resident was noted to have dried dispersed scratches on the left side of the upper chest as well. When the resident was asked by this nurse what happened to it, the resident stated, Oh, I probably scratched it earlier. b. Medical record review for Resident 2 was initiated on 9/4/24. Resident 2 was admitted to the facility on [DATE]. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's MDS Section C dated 6/26/24, showed Resident 2 had a BIMS summary score of 6, indicating severe cognitive impairment. Review of Resident 2's Nurse Progress Note dated 8/29/24 at 1525 hours, showed two CNAs went to the resident's room due to hearing commotion. The staff noted Resident 1 holding Resident 2's hand. Resident 2 stated Resident 1 bit her. Resident 2 was assessed and noted with a bite mark on the right hand. Review of Resident 2's Skin Evaluation PRN/Weekly dated 8/29/24 at 1410 hours, showed Resident 2 was status post alleged altercation with another resident. Upon assessment, Resident 2 verbalized a new wound allegedly caused by roommate. Resident 2 was noted to have a deep laceration measuring 1.5 cm by 0.3 cm. Review of the physician's orders showed an order dated 8/29/24, to cleanse the right hand bite with normal saline, apply triple antibiotic ointment, and cover with a dry dressing for 7 days. On 9/4/24 at 1132 hours, an interview was conducted with LVN 4. LVN 4 verified Resident 1 mentioned Resident 2 scratched her and in response, she had bitten Resident 2 in self-defense. On 9/4/24 at 1348 hours, a telephone interview was conducted with CNA 5. CNA 5 stated she heard loud noise and saw Resident 1 had bit Resident 2's hand. CNA 5 verified Resident 1 stated she bit Resident 2 in self-defense because Resident 2 scratched her (Resident 1) on the right side of her face.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 49324 Based on interview, medical record review and facility P&P review, the facility failed to develop a plan of care to reflect the individual care needs for one of six sampled residents (Resident 3). * The facility failed to develop a care plan problem to address Resident 3's refusal of taking medications. This posed the risk of not providing appropriate, consistent, and individualized care to the resident. Findings: Review of the facility's P&P titled Comprehensive Resident Centered Care Plan revised 1/2021 showed it is the policy of this facility that the interdisciplinary team shall develop and implement a comprehensive person - centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A baseline care plan shall be developed within 48 hours of admission. A comprehensive care plan is developed within 7 days of completion of the Resident Minimum Data Set and will be updated as needed. Medical record review for Resident 3 was initiated on 9/4/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Nurse Progress Notes showed the following notes: - dated 9/2/24 at 1554 hours, showed Resident 3 was refusing to take their medications at this time and was shouting random sentences. - dated 9/2/24 at 2348 hours, showed Resident 3 again refused the medications and was yelling and calling out. Review of Resident 3's care plans failed to show a care plan problem was developed for Resident 3's refusal to take medications. On 9/6/24 at 1600 hours, an interview was conducted with the DON. The DON verified there was no care plan for refusal of medications.

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 49324 Based on observation, interview, and facility P&P review, the facility failed to comply with the State law when two staff (CNAs 2 and 6) were not wearing their name badges while on duty. This failure had the potential to place the residents at risk to be cared for by unidentified persons. Findings: According to Title 22, Article 5, Administration, S72501 (h), showed the licensee shall ensure that all employees serving patients, or the public shall wear name and title badges unless contraindicated. Review of the facility's P&P titled Identification Badges revised 4/2004 showed all employees must wear identification badges. Further review of the policy showed all personnel are required to wear identification tags/badges during their work shifts. On 9/4/24 at 1310 hours, a concurrent observation and interview was conducted with CNA 2. CNA 2 was observed wearing a visitor sticker badge. CNA 2 verified he was not wearing his employee name badge and stated it was important to wear it so the residents would know who he was. On 9/5/24 at 1312 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 was wearing a visitor sticker badge. CNA 6 verified she was not wearing her employee name badge and stated it was important to wear it so the residents would know who she is. On 9/6/24 at 1600 hours, an interview was conducted with the DON. The DON stated the facility ran out of the temporary sticker name badge. The DON verified it was important to wear an employee identification badge so the residents would know who the employees were and it would be easier to direct to the staff when the family member and/or visitors needed something.