STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical record for one of two sampled residents (Resident 1) was accurately maintained. The facility failed to show the RNA services were provided to Resident 1 as ordered by the physician. This posed the risk of not addressing and providing appropriate care for Resident 1. Findings: Closed medical record review for Resident 1 was initiated on 5/28/2020. The medical record showed Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the order dated 4/7/2020, for RNA to assist Resident 1 with ambulation three times a week as tolerated. Review of Resident 1's Documentation Survey Report for April 2020 showed the RNA services were not provided to Resident 1 on 4/17, 4/22, 4/27, and 4/29/2020, as ordered by the physician. On 5/28/2020 at 1500 hours, an interview was conducted with RNA 2. RNA 2 stated Resident 1 was weak and required assistance of two staff members for ambulation. RNA 2 stated Resident 1 was able to walk approximately 20 feet. RNA 2 stated they documented in the Restorative Nursing Summary Sheet after the RNA services were provided. On 6/28/2020 at 1406 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the above finding. The DON stated the RNA should sign electronically when they provided the RNA services to the resident, or document if the resident refused the RNA services.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.