| 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 _____ | 08/13/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| 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) |
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| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive plan of care for one of two sampled residents (Resident 1) was revised to reflect the resident's current nutritional needs and interventions. This posed the risk of not providing Resident 1 with individualized and person-centered care. Findings:<br>Medical record review for Resident 1 was initiated on 7/24/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Weights and Vitals Summary from 1/23/20 to 7/23/20, showed the following documented weights taken on: - 3/14/20 = 133.4 pounds - 3/22/20 = 130.2 pounds - 3/29/20 = 127.6 pounds; - 4/5/20 = 125.2 pounds, a 6% weight loss in less than one month - 4/19/20 = 118.2 pounds, a 9% weight loss in one month - 5/5/20 = 113 pounds, an additional 9% weight loss in one month - 5/19/20 = 107.6 pounds, a 5% weight loss in one week. This was a loss of 25.8 pounds in 65 days. Review of Resident 1's plan of care showed a care plan problem to address nutrition initiated on 3/14/20. The care plan problem showed an intervention to offer meal replacement to Resident 1 if the resident consumed less than 75% of their meal. Other interventions included to provide the resident a sugar free health shake, honor to make dietary choices, and invite to activities that promote additional intake. However, the care plan failed to show updated interventions after Resident 1 had been identified with a significant weight loss on 4/19 and 5/19/20. On 8/11/2020 at 1620 hours, a telephone interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the above findings. The DON stated Resident 1's weight loss was considered significant and should have been updated in the resident's plan of care. Cross reference to F692. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, medical record review, and facility P&P review, the facility failed to provide necessary care and services related to significant weight loss for one of two sampled residents (Resident 1) to ensure the resident maintained an acceptable nutritional status. * The facility failed to follow an RD recommendation for weekly weights after Resident 1 had a significant weight loss in one month (9% weight loss). * The facility failed to follow repeated RD recommendations to provide 120 ml of Med-Pass drinks (a fortified nutritional drink) to Resident 1 due to their significant weight loss. These failures had the potential for not meeting Resident 1's nutritional needs and preventing further weight loss. Findings:<br>Review of the facility's P&P titled Policy/Procedure Nursing Administration revised 01/2019, showed any resident's weight that varies from the previous period by 5% in 30-days, 7.5% in 90-days and 10% in 180-days will be evaluated by the IDT team to determine the cause of weight loss/gain and intervention required. The care plan will be updated and revised as appropriate. Medical record review for Resident 1 was initiated on 7/24/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Nutrition Evaluation and RD (Registered Dietician) Review dated 3/16/20, showed Resident 1's usual weight was 130 pounds (plus/minus 10 pounds). Review of Resident 1's Weights and Vitals Summary from 1/23/20 to 7/23/20, showed the following documented weights taken on: - 3/14/20 = 133.4 pounds - 3/22/20 = 130.2 pounds - 3/29/20 = 127.6 pounds; - 4/5/20 = 125.2 pounds, a 6% weight loss in less than one month - 4/19/20 = 118.2 pounds, a 9% weight loss in one month - 5/5/20 = 113 pounds, an additional 9% weight loss in one month - 5/19/20 = 107.6 pounds, a 5% weight loss in one week. This was a loss of 25.8 pounds in 65 days. Review of Resident 1's Nutrition Interdisciplinary Team Update dated 4/7/20, showed Resident 1 had a significant weight loss for three weeks related to resolution of [MEDICAL CONDITION] and varied oral intake. The IDT recommendations showed to add extra gravy and sauce to Resident 1's meal entrees, obtain weekly weights, and provide 120 ml of Med-Pass three times daily with medications. Review of Resident 1's Nutrition Interdisciplinary Team Update dated 4/21/20, showed the team had met to discuss Resident 1's significant weight loss with meal intakes varying from 25 to 50%. The IDT recommendation was to add an appetite stimulant, a banana at every breakfast, 120 ml of Med-Pass three times a day, and encourage Resident 1 to drink 210 ml of water at every medication pass. Review of Resident 1's Nutrition Interdisciplinary Team Update dated 5/11/20, showed the team met to discuss Resident 1's significant weight loss of 20.4 pound (14.9%) in one month related to resolution of [MEDICAL CONDITION] and poor oral intake. The IDT recommendation showed to add 240 ml of fluids with medication pass three times a day and conduct weekly weights for four weeks. Review of Resident 1's Nutrition Interdisciplinary Team Update dated 5/20/20, showed the team had met to discuss Resident 1's 5.4% weight loss in two weeks related to poor oral intake and [DIAGNOSES REDACTED]. Resident 1 required medium to total assistance with meals. The IDT recommendation was to add supplements to meal trays to increase fluids and oral intakes and for a CNA to assist Resident 1 with meals. Review of Resident 1's Order Summary Report showed the following; - 4/12/20, obtain weekly weights every Monday, on the day shift, for four weeks. - 5/12/20, administer 240 ml of fluids with each medication pass three times a day. Review of the medical record failed to show documentation Resident 1's weight was obtained between 4/20 to 5/4/20 and 5/6 to 5/18/20. Review of Resident 1's medical record failed to show a physician's orders [REDACTED]. The medical record also failed to show an order for [REDACTED]. The RD verified Resident 1's medical record failed to show Resident 1's weight was recorded weekly after her recommendation on 4/7/2020. When asked why she believed the resident was having poor oral intake, the RD stated it was the CNAs' responsibility to offer the resident assistance with meals and offer an alternative food if they do not like the food served. When asked what Resident 1 stated about her food preferences and whether she liked the food, the RD stated she was not able to see the resident or discuss her food preferences after her initial assessment in March 2020. When asked for her nutrition assessments to address the weight loss, the RD stated the IDT meetings were considered as her progress notes. On 8/11/20 at 1620 hours, a telephone interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the RD's recommendation for weekly weights were not done. The DON verified there was no documentation to explain why Resident 1 was not reassessed for three weeks following the 4/19/20 weight of 118.2 pounds, a significant weight loss of 30 pounds (9%) in one month. The DON verified Resident 1's weight loss was considered significant and should have been reevaluated timely. On 8/12/20, a follow-up telephone interview and concurrent medical record review was conducted with the RD. The RD verified on 4/7, 4/21, and 5/11/20, she recommended had 120 ml of Med-Pass to be administered three times daily with medications. The RD verified her repeated recommendation to give 120 ml of Med-Pass to Resident 1 three times daily was not carried out. The RD was asked how she kept track of her recommendations made during IDT meetings. The RD stated she would look at the resident's chart and made sure the order was followed. On 8/13/2020 at 1645 hours, a follow-up telephone interview was conducted with the DON. The DON verified the above findings. Cross reference to F657. |

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