STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development or worsening of pressure injuries for three of six sampled residents (Residents 2, 4, and 5). Findings: * Resident 2's pressure injuries were not measured and assessed weekly. In addition, no pictures were taken as per the facility's protocol. * Resident 2's low air loss mattress was set too high for Resident 2's weight. * Resident 4's low air loss mattress was set too high for Resident 4's weight. * Resident 5's low air loss mattress was set too high for Resident 5's weight. These failures posed the risk for the residents to develop new pressure injuries and for existing pressure injuries to get worse. Findings: 1. Review of the facility's P&P titled Prevention/Management of Pressure Ulcers/Injuries revised 12/2022 showed the following: - to ensure weekly observation is completed and all changes are documented accordingly in the medical record; and - for Stages 3, 4, UTD, and DTI pressure injuries, to utilize Skin and Wound module in PCC; and utilize photograph function in wound module for visual tracking and recording of wound progress and size until healed. Medical record review for Resident 2 was initiated on 8/30/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's H&P examination dated 7/2/24, showed Resident 2 was bedbound and had multiple infected wounds. The H&P examination also showed Resident 2 had the capacity to make medical decisions. Review of Resident 2's Nursing Comprehensive Skin Evaluation/assessment dated [DATE], showed Resident 2 had a Stage 4 pressure injury to the sacrum and right lateral knee; and unstageable pressure injury to the sacrum and right lateral knee; and unstageable pressure injury to the right and left ankles, left toe, right lateral upper foot, right lower lateral foot, and right heel. Further review of Resident 2's medical record showed Resident 2 had been receiving the daily wound treatments as ordered by the physician. However, there was no documented evidence the weekly wound assessments including wound measurements and pictures were completed as per the facility's P&P. There were no weekly wound assessments done on Resident 2 between 7/22/24 and 9/2/24. On 8/30/24 at 1115 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 stated he had several wounds on both legs, but the left leg was the worst and one part of the wound was still with discharges and he also had a wound at his bottom. Resident 2 further stated the nurses changed his wound dressing every day. On 9/5/24 at 1445 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 stated she did the initial skin assessment for Resident 2 when he was admitted on [DATE]. LVN 3 stated the treatment nurse was responsible for the weekly wound assessments, including the wound description, size measurements, and photos; and must be documented. LVN 3 verified her last documented weekly wound assessment for Resident 2 was on 7/22/24, then she reassessed the resident's wound when she got back from her leave on 9/2/24. On 9/6/24 at 1440 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the above findings. 2. Review of the facility's P&P titled Beds, Special - Low Air Loss Therapy revised 9/2024 showed pressure adjustments for comfort may be made by the trained facility staff in accordance with the resident condition and need. Review of the Comfort Level Reference Chart for the low air loss mattress located at the side of the machine showed the level is to be determined by the resident's weight distribution. The label showed the weight and corresponding setting for comfort level. For the residents weighing 75 lbs = 3.5-4, 100 lbs = 4, 125 lbs = 4.5, 150 lbs = 5, 175 lbs = 5-6, 200 lbs = 6-7, 250 lbs = 7-8, 300 lbs = 8-9, 350 lbs = 9, and 400 lbs = 10. a. Medical record review for Resident 2 was initiated on 8/30/24. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 7/2/24, showed Resident 2 had a history of being bedbound and multiple pressure ulcers. The H&P also showed Resident 2 had the capacity to make medical decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 7/14/24, to provide a pressure reducing mattress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Monthly Weight Report for August and September 2024 showed Resident 2 weighed 173 lbs in August and 166 lbs in September. On 9/5/24 at 0900 hours, an interview and concurrent observation was conducted with LVN 3. Resident 2 was observed lying on his back on a low air loss mattress. The control panel for the low air loss mattress indicated the comfort level setting was set to levels 8-9. LVN 3 stated according to the weight guidelines for the low air loss mattress, Resident 2's mattress comfort level setting should have been set to levels 5-6. LVN 3 stated the low air loss mattress was set 125 lbs higher than it should have been. LVN 3 stated the low air loss mattress was set too firm for Resident 2's weight, which would put more pressure on areas of Resident 2's body. LVN 3 stated the purpose of the low air loss mattress was to prevent pressure points on Resident 2's body by circulating air flow. LVN 3 stated the firmer mattress was putting pressure on Resident 2's sacral area. b. Medical record review for Resident 4 was initiated on 9/9/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/2/24, showed Resident 4 had a Stage 3 pressure injury to her upper back. The H&P examination also showed Resident 4 did not have the capacity to make medical decisions. Review of Resident 4's Order Summary Report showed a physician's order dated 8/31/24, to provide a pressure reducing mattress. Review of Resident 4's Monthly Weight Report for August 2024 showed Resident 4 weighed 182.1 lbs. On 9/5/24 at 1255 hours, a concurrent interview and observation was conducted with RN 2. Resident 4's low air loss mattress setting was observed to be set at a comfort level of 7-8. RN 2 checked the mattress Comfort Level Reference Chart and stated levels 7-8 would be for a patient who weighed 250 lbs. RN 2 acknowledged Resident 4 did not look like she weighed 250 lbs. c. Medical record review for Resident 5 was initiated on 9/5/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 11/21/23, showed Resident 5 had a diagnosis of quadriplegia. Review of Resident 5's Order Summary Report showed a physician's order dated 11/3/22, to provide low air loss mattress for skin management and to set according to the resident's weight every shift for skin management. Review of Resident 5's Care Plan showed a care plan problem initiated on 5/31/22, addressing Resident 5's high risk for altered skin integrity. The interventions included low air loss mattress as ordered. Review of Resident 5's Monthly Weight Report for August and September 2024 showed Resident 5 weighed 160 lbs. in August and 165.4 lbs. in September. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 1255 hours, a concurrent interview and observation was conducted with RN 2. Resident 5 was observed lying on a low air loss mattress. Resident 5's low air loss mattress was set at levels of 7-8. Review of the mattress Comfort Level Reference Chart indicated a comfort level of 7-8 was for a person who weighed 250 lbs. On the top of Resident 5's mattress control panel had a handwritten label showing 5-6. RN 2 stated he did not realize the label indicated what the comfort level settings were supposed to be at and confirmed the settings were too firm for Resident 5. On 9/9/24 at 1450 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement and maintain their infection control program for two of six sampled residents (Residents 2 and 6) as evidenced by: * LVN 1 failed to wear a disposable gown as required for EBP prior to performing the wound care to Resident 2. * LVN 1 failed to establish a clean field to place the clean and sterile wound supplies for Resident 2. * LVN 3 failed to wear a disposable gown as indicated for EBP while performing wound care and to establish a clean field to place the wound supplies while performing wound care for Resident 2. * CNA 1 failed to wear a disposable gown as indicated for EBP during transfer and repositioning of a resident. These failures have the potential risk of transmission of disease-causing microorganisms and infections to the residents. Findings: Review of the facility's P&P titled Enhanced Barrier Precautions revised 8/2022 showed the following: - Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. - EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. - EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room); and - Examples of high contact resident care activities requiring the use of gown and gloves for EBPs included wound care (any skin opening requiring a dressing), bathing, showering, and transferring. Review of the facility's P&P titled Wound Care, (undated), under the section for Steps in the Procedure showed the following: - use of a disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- be certain all clean items are on the clean field, - use clean field saturated with alcohol to wipe overbed table, - return the overbed table to its proper position, - wipe reusable supplies with alcohol as indicated. Return supplies to resident's drawer in the treatment cart, and - take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. 1. Medical record review for Resident 2 was initiated on 8/30/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 7/2/24, showed Resident 2 was bedbound and had multiple infected wounds. The H&P examination also showed Resident 2 had the capacity to make medical decisions. Review of Resident 2's Order Summary Report dated August 2024 showed the physician's orders for the following: - on 7/15/24, for isolation with EBP related to wounds/midlines and may cohort every shift; - on 8/23/24, for the left lateral lower leg vascular wound to be cleansed with normal saline, pat dry, apply Santyl collagen (for wound debridement) and abdominal pad, and wrap with kerlix every day shift for wound care for 30 days; - on 8/23/24, for the left lateral malleolus vascular wound to be cleansed with normal saline; pat dry; apply collagen, calcium alginate (a water-insoluble, gelatinous, cream-colored substance for wound care), and abdominal pad; then wrap with kerlix every day shift for wound care for 30 days; - on 8/23/24, for the right lateral foot UTD pressure injury to be cleansed with normal saline, pat dry, apply Santyl collagen and abdominal pad, then wrap with kerlix every day shift for wound care for 30 days; - on 8/23/24, for the right lateral foot vascular wound to be cleansed with normal saline, pat dry, apply collagen and abdominal pad, then wrap with kerlix every day shift for wound care for 30 days; - on 8/23/24, for the right lateral lower leg inferior vascular wound to be cleansed with normal saline; pat dry; apply Santyl collagen, calcium alginate, and abdominal pad; then wrap with kerlix every day shift for wound care for 30 days; - on 8/23/24, for the right lateral malleolus vascular wound to be cleansed with normal saline; pat dry; apply Santyl collagen, calcium alginate, and abdominal pad; then wrap with kerlix every day shift for wound care for 30 days; and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 8/26/24, for the Stage 4 sacrum pressure injury to be cleansed with normal saline, pat dry, apply Medi-honey (to treat wound infection, or reducing bacteria level) and calcium alginate, and cover with a foam dressing every day shift for wound care healing for 14 days. a. On 8/30/24 at 1115 hours, an observation and concurrent interview was conducted with Resident 2. A door signage for EBP was observed posted on the wall outside Resident 2's door and a storage organizer was observed on the wall in front of Resident 2's bed containing disposable gowns, gloves, and masks. An EBP signage was also observed posted on the wall by Resident 2's head part of the bed. Resident 2 was asked if he had wounds, Resident 2 stated he had several wounds on both legs, but the left leg was the worst, and one area was still with discharges, and he also had a wound at his bottom. Resident 2 further stated the nurses changed his wound dressing every day. On 9/4/24 at 1150 hours, a wound care observation for Resident 2 was conducted with LVN 1. LVN 1 was observed placing a clear plastic bag underneath Resident 2's left leg and foot with gloves on, then proceeded to remove the old dressings from the left foot and leg and placed the soiled dressings in the plastic bag. LVN 1 doffed her gloves, performed hand hygiene, and donned new gloves and proceeded with the wound care on the left lateral lower leg. The left lateral lower leg wound was observed draining with light red color of drainage and LVN 1 was observed not wearing a disposable gown. After LVN 1 applied a dry dressing to cover Resident 2's wound, LVN 1 doffed her gloves, performed hand hygiene, and proceeded to wear a disposable gown to continue with the rest of Resident 2's wound care treatment to both legs and sacrum. LVN 1 stated she usually did not wear the gown because she got allergic reactions at times. When asked if LVN 1 told her supervisors or the management about it, LVN 1 did not respond. On 9/4/24 at 1420 hours, an interview with LVN 1 was conducted. LVN 1 was observed without any signs and symptoms of allergic reaction from wearing the disposable gown during the wound care. LVN 1 was informed of the observations during wound care treatment for Resident 2. LVN 1 stated the EBP signage outside the resident's door indicated the staff had to wear both gloves and gown when doing wound care. LVN 1 acknowledged the above findings and stated she missed donning a gown prior to performing the wound care treatment for Resident 2. On 9/4/24 at 1535 hours, an interview was conducted with the IP. The IP stated the facility staff were expected to always follow the EBP precautions when doing high contact resident activities like wound care to prevent cross contamination and the spread of bacteria or infection between the residents as well as to the staff. The IP was informed and acknowledged the above findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 9/4/24 at 1150 hours, a wound care observation for Resident 2 was conducted with LVN 1. LVN 1 was observed preparing all the wound care supplies to be used for Resident 2's wound care treatment. LVN 1 placed the sealed disposable dry gauze, kerlix wrap, foam dressings, disposable wooden spatulas, tape, normal saline, and wound ointments in medicine cups inside a blue plastic box container. LVN 1 walked to Resident 2's bedside and placed the blue container containing the wound care supplies directly to Resident 2's bed and proceeded with the wound care. LVN 1 was observed taking some wound care supplies out of the blue container and putting it directly on top of Resident 2's bedsheet including the gauze, kerlix, and wound ointment. The blue container was on Resident 2's bed throughout the wound care treatment. After the wound care treatment was completed, LVN 1 was observed placing the blue container with some of the unused wound care supplies on top of the treatment cart without cleaning the blue container, then LVN 1 proceeded to put the treatment cart in the hallway and headed to the nurse's station. On 9/4/24 at 1420 hours, LVN 1 was informed of the observations during wound care treatment for Resident 2. LVN 1 stated she did not want to use the overbed table because Resident 2 was using it for eating. LVN 1 acknowledged she could have placed a clean drape on it but missed it. LVN 1 stated she wiped and sanitized the treatment cart at the end of her shift and sometimes she would just throw the containers when heavily soiled. LVN 1 stated she threw the blue container she used as well as the supplies not used. LVN 1 further stated she did not wipe the top of the treatment cart yet, but she would do it now. On 9/4/24 at 1535 hours, an interview was conducted with the IP. The IP stated the practice during wound care was to use the overbed table as indicated in the facility's policy. The nurse could get an extra overbed table to use if the overbed table at the resident's room was occupied with the resident's belongings. The IP further stated any reusable supplies including the outsides of the containers that were touched by unclean hands should be wiped with alcohol prior to returning in the treatment cart. The IP stated the staff were expected to always observe proper infection control measures to prevent cross contamination and spread of bacteria or infection. The IP was informed and acknowledged the above findings. c. On 9/5/24 at 0900 hours, an interview and concurrent observation was conducted with LVN 3. LVN 3 was observed at Resident 2's bedside picking up bloody gauze and used tape from the top of Resident 2's bed cover then putting the contaminated items into a garbage bag. An EBP signage was observed posted on the wall above Resident 2's bed. LVN 3 was observed not wearing a disposable gown. LVN 3 stated she just finished the dressing change on Resident 2. LVN 3 stated she performed wound care on Resident 2's legs and lower back. LVN 3 stated she did not wear a disposable gown during the wound dressing change procedure for Resident 2. LVN 3 stated she should have been wearing a gown. When LVN 3 was asked why Resident 2 was on EBP precautions. LVN 3 stated it was because Resident 2 had open wounds and a urinary catheter. Resident 2's bedside table was observed with Resident 2's personal items on it. LVN 3 stated she did not use the bedside table for the dressing supplies. When LVN 3 was asked why she did not use the bedside table, LVN 3 stated she put the supplies on the bed, but it had a sheet under them. LVN 3 stated the bedside table was supposed to be used for dressing changes, but Resident 2 had his personal items on it. 2. Medical record review for Resident 6 was initiated on 9/5/24. Resident 6 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's H&P examination dated 6/4/24, showed Resident 6 had the capacity to understand and make medical decisions. Resident 6 had diagnoses of pressure injury to the sacrum and incisions to both legs. Review of Resident 6's Order Summary Report showed an order dated 6/3/24, for isolation with EBP related to indwelling urinary catheter and wounds. On 9/5/24 at 1048 hours, a concurrent interview and observation was conducted with CNA 1. CNA 1 and Student 1 were observed wheeling Resident 6 down the hall into Resident 6's room, on a shower chair. CNA 1 and Student 1 were not wearing disposable gowns. CNA 1 and Student 1 had assisted Resident 6 from the shower chair and into his bed. An EBP signage was observed posted on the wall above Resident 6's bed. CNA 1 stated they should have been wearing the disposable gowns. On 9/5/24 at 1351 hours, an interview was conducted with the IP. The IP was informed about the observation regarding the care of Resident 6 as he returned from his shower. The IP stated the staff should wear disposable gowns when showering, transferring, or assisting a resident who was on EBP.