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	09/20/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report an allegation of staff-to-resident abuse to the law enforcement agency, CDPH L&C Program, and Ombudsman office (an advocate for long term residents) for one of three sampled residents (Resident 1). This failure had the potential to put residents at risk for further abuse. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting revised November 2017 showed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall promptly report to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE], with diagnosis of hemiplegia (paralysis in one side of the body) and hemiparesis (weakness or inability to move in one side of the body) affecting the right dominant side. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 10, indicating moderate cognitive impairment. On 9/17/24 at 0946 hours, a telephone interview was conducted with the anonymous complainant. The anonymous complainant alleged CNA 1 abused Resident 1 on 9/3/24. According to the anonymous complainant, the incident was reported by Family Member 1 to the Administrator and DON. On 9/17/24 at 1333 hours, an interview was conducted with the DON. The DON was asked regarding the allegation of abuse which occurred on 9/3/24, involving Resident 1 and CNA 1. The DON stated the incident was reported by the Activity Director on 9/3/24. Family Member 1 also reported the incident to the DON and Administrator. The DON confirmed no report was made to the CDPH L&C Program, law enforcement agency, and Ombudsman office regarding the incident. The DON confirmed the alleged abuse was not documented. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 1022 hours, a telephone interview was conducted with Family Member 1. Resident 1 told Family Member 1 about the incident. Family Member 1 was asked how they identified the male staff who allegedly abused Resident 1. Family Member 1 stated when CNA 1 walked into Resident 1's room, Resident 1 got petrified and pointed to CNA 1. Family Member 1 informed the DON of the incident. On 9/18/24 at 1508 hours, a telephone interview was conducted with MD 1. MD 1 stated the incident was told by Resident 1 on 9/3/24. MD 1 discussed the incident to the SSD and reported to the incident to the Administrator. On 9/18/24 at 1525 hours, an interview was conducted with Resident 1. Resident 1 was asked about the incident which happened two weeks ago. Resident 1 became teary eyed and looked frightened. Resident 1 stated, They were very mean to me. Resident 1 was asked if it was a female staff, Resident 1 stated no. When asked if it was a male staff, Resident 1 nodded. Resident 1 demonstrated how the male staff covered Resident 1's mouth and further stated I am so scared. On 9/20/24 at 1130 hours, the Administrator acknowledged above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, and facility P&P review, the facility failed to implement their abuse P&P related to investigation of the physical abuse for one of three sampled residents (Resident 1). * The facility failed to complete a thorough investigation including to conduct the interview of the person(s) reporting the incident, any witnesses to the incident, the resident, the staff members from different shifts and disciplines, resident's roommate if appropriate, family members, other residents to whom the accused employee provides care or services and report the result of the investigation to the CDPH L&C Program, Orange District Office within five working days. This failure posed the risk for the potential abuse to remain unidentified and for the residents to go unprotected. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting revised November 2017 showed the individual conducting the investigation will, as a minimum, interview the person(s) reporting the incident, witnesses to the incident, the resident, staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, resident's roommate if appropriate, family members, and other residents to whom the accused employee provides care or services. The Administrator, his/her designee will provide the appropriate agencies or individuals listed above with a written repost of the findings of the investigation within five working days of the occurrence of the incident. Medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE], with diagnosis of hemiplegia and hemiparesis affecting the right dominant side. On 9/17/24 at 0946 hours, a telephone interview was conducted with the anonymous complainant. The anonymous complainant alleged CNA 1 abused Resident 1 on 9/3/24. The incident was reported by Family Member 1 to the Administrator and DON. On 9/17/24 at 1333 hours, an interview was conducted with the DON. The DON was asked about the allegation of abuse which occurred on 9/3/24, involving Resident 1 and CNA 1. The DON stated the incident was reported by the Activity Director on 9/3/24. Family Member 1 also reported the incident to the DON and Administrator. The DON was asked if an investigation was done. The DON stated only CNA 1, the alleged perpetrator was interviewed. The DON confirmed the alleged abuse was not documented. On 9/20/24 at 1130 hours, the Administrator acknowledged above findings. Cross reference to F609.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **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 provide the necessary services related to foot care for one of three sampled residents (Resident 2). * The facility failed to ensure the skin check, accurate assessment, and monitoring of Resident 2's bilateral feet after the podiatry care for fungal infection, including debridement and nail trimming. This failure had the potential to negatively impact the resident's health and well-being. Findings: Review of the facility's P&P titled Charting and Documentation revised on 7/2017 showed all facility services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2. The following information is to be documented in the resident medical record: a. Objective observations b. Medications administered c. Treatments or services performed. d. Changes in the resident's condition e. Events, incidents or accidents involving the resident; and f. Progress toward changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective, complete, and accurate. Review of the facility's P&P titled Care Plans, Comprehensive Person Centered revised 3/2022 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 11. Assessments of residents are ongoing and care plan are revised as information about the residents and the resident's condition change. Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS Section C dated 9/12/24, showed Resident 2 had a BIMS score of 6, indicating severe cognitive impairment. Review of Resident 2's MDS Section GG dated 9/12/24, showed Resident 2 needed partial assistance from another person to complete any activities as: self-care, indoor mobility (ambulation) and functional cognition. Review of Resident 2's Order Summary Report dated 9/1/24-9/30/24, showed Resident 2's diagnosis included Type 2 Diabetes Mellitus with other specified complications. Review of Resident 2's care plan dated initiated 7/14/24, showed a care plan problem addressing Resident 2 was at risk for altered skin integrity. The interventions included to monitor for any signs of skin breakdown (sore, tender, red, or broken areas). (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Convalescent Podiatry Care Evaluation & Treatment dated 8/19/24, showed Resident2's assessment/diagnosis included nail dystrophy and Tinea Unguium (a fungal infection of the nail that causes discoloration, thickening, and other changes to the nail), with evaluation of thickened, discolored, brittle with subungual debris and painful toenail(s) upon palpation on the right and left 1-5 toes. The treatment plan/procedure performed was debridement and trimming of nails utilizing nail [NAME] and Dremel of ten mycotic, hypertrophic, painful, incurvated toenails. Further review of Resident 12's medical record failed to show documented evidence a care plan was developed to address the resident's fungal infection of the nail that resulted in debridement to be performed by the podiatrist. There was no documentation of the bilateral feet/toes skin assessment and monitoring of the debridement site or pain assessment related to the procedure on 8/19/24. Review of Resident 2's SBAR Communication Form and Progress Note for RNs/LPN/LVNs dated 9/1/24 at 0923 hours, showed there was a change in condition, symptoms, or signs observed and evaluated on 9/1/24, and the condition symptom, or signs had not occurred before. The appearance/summarized observation and evaluation section of the SBAR showed it was reported by the CNA that the resident had swelling of the right foot and right second toe with slight redness and minimal drainage. The documentation showed the physician had ordered to transfer Resident 2 to the acute care hospital. On 9/19/24 at 1327 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked to show any documentation of the monitoring of any skin breakdown and care plan for Resident 2's bilateral feet/toes since the last time Resident 2 received podiatry care and treatment on 8/19/24, with diagnosis of nail dystrophy and Tinea Unguium. The DON was not able to provide any documentation and verified there were no monitoring, assessment, and care plan for the bilateral feet/toes related to the procedure on 8/19/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was provided non-pharmacologic intervention for the use of psychotropic medication (medication that affects the mind, emotions, and behavior). This failure had the potential for Resident 1 to have adverse complications from the medication. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised July 2022 showed non-pharmacological approaches are used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Medical record review for Resident 1 was initiated on 9/17/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report for September 2024 showed a physician's order dated 7/11/24, to administer Lexapro oral 5 mg tablet by mouth one time a day for depression as manifested by tearful episodes. Review of Resident 1's Progress Note dated 9/11/24, showed a new physician's order to increase the dose of Lexapro medication to 10 mg daily. Review of Resident 1's Therapist Progress Note dated 9/19/24, showed a recent increase of Lexapro dosage due to tearful episodes with depression. Review of Resident 1's MAR for August and September 2024 for the monitoring of the episodes of depression as evidenced by tearful crying showed the following: - On 8/1/24, three episodes during the day shift and three episodes during the evening shift; - On 8/7/24, three episodes during the day shift; - On 8/20/24, one episode during each shift. - On 8/21/24, three episodes during the day shift; - On 8/22/24, four episodes during the evening shift; - On 8/23/24, six episodes during the morning shift; - On 8/25/24, five episodes during the morning shift and five episodes during the evening shift; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 8/27/24, four episodes during the evening shift; - On 8/29/24, four episodes during the evening shift and three episodes during the night shift; - On 8/30/24, four episodes during the day shift, six episodes during the evening shift, and six episodes during the night shift; - On 8/31/24, six episodes during each shift. - On 9/4/24, three episodes during the day shift; - On 9/6/24, one episode during the evening shift; - On 9/7/24, one episode during the day shift. There was no documented evidence of any non-pharmacological interventions provided for Resident 1. Further review of Resident 1's care plan problem addressing the use of Lexapro medication failed to show documentation of interventions for the non-pharmacological implementation for the use of the above medication. On 9/20/24 at 0920 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated Resident 1 received Lexapro daily in the morning and was monitored every shift for side effects and manifestation of tearfulness. The DON was unable to find any documentation for the non-pharmacological interventions provided when Resident 1 had episodes of tearfulness. The DON also verified there was no care plan for the non-pharmacologic interventions for the use of Lexapro medication.