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	11/12/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of two sampled residents (Resident 2) to help attain and maintain their highest practicable physical well-being. * The facility failed to ensure Resident 2's Senna (stool softener), enoxaparin (anticoagulant medication), acetaminophen (analgesic), gabapentin (anticonvulsant and nerve pain medication) and nystatin suspension (antifungal medication) were administered as per the physician's order. This failure had the potential to negatively impact the resident's well-being. Findings: Review of facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner and as prescribed. If a drug is withheld, refused, or given at a time other than scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before the next ones. Review of Resident 2's medical record was initiated on 11/8/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS Admission assessment dated [DATE], showed the resident's BIMS score of 14, indicating the resident's cognition was intact. Review of Resident 2's physician's order for 10/10/24 to 11/08/24, showed the following orders: - dated 10/17/24, Senna 8.6 mg one tablet by mouth at bedtime for bowel management (hold for loose stools). - dated 10/10/24, enoxaparin sodium injection solution prefilled syringe 80 mg/0.8 ml subcutaneously every 12 hours for DVT. - dated 10/17/24, acetaminophen 500 mg two tablets by mouth every eight hours for pain management, not to exceed 3 gm of APAP (same as acetaminophen) in 24 hours. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/10/2024, gabapentin 300 mg one capsule by mouth three times a day for neuropathic (known as nerve pain, is a type of chronic pain caused by damage or disease to the nervous system) pain - dated 10/10/24, Nystatin Suspension 100,000 unit/ml 5 ml (total of 500,000 units) by mouth swish and swallow four times a day for mouth fungal or yeast infection for 10 days Review of Resident 2's MAR for October 2024 showed the following medications were not administered: - on 10/20/24 at 2100 hours, Senna 8.6 mg one tablet by mouth at bedtime for bowel management (hold for loose stools). - on 10/20/24 at 2100 hours, enoxaparin sodium injection solution prefilled syringe 80 mg/0. 8 ml subcutaneously every 12 hours for DVT. - on 10/20/24 at 2200 hours, acetaminophen 500 mg two tablets by mouth every eight hours for pain management, not to exceed 3 gm of APAP in 24 hours. - on 10/20/24 at 2200 hours, gabapentin 300 mg one capsule by mouth three times a day for neuropathic pain. - on 10/20/24 at 2100 hours, Nystatin Suspension 100,000 unit/ml 5 ml (total of 500,000 units) by mouth swish and swallow four times a day for mouth fungal or yeast infection for 10 days. Further review of the MAR failed to show documentation if the medications were held for any reason. Further review of Resident 2's MAR showed Resident 2 had a pain level of 6 (on a 0 to 10 pain scale with 0 = no pain and 10 = worst pain) on 10/20/24 at 2300 hours. Resident 2 was given hydromorphone hydrochloride (opioid) 2 mg one tablet by mouth for moderate pain. On 11/8/24 at 1028 hours, an interview was conducted with Resident 2. Resident 2 stated she did not receive her enoxaparin sodium injection and some other medications for pain for a couple of times. Resident 2 stated she notified a nurse and was told the medications were supposed to be given on time and the resident could not get the medication if beyond the scheduled time. Resident 2 further stated she suffered a lot of pain when she did not get her medications and had to ask for stronger pain medication. On 11/8/24 at 1224 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the above medications were not initialed in the MAR. The DON verified the above medications were not administered as ordered. The DON stated the medications were expected to be administered as ordered by the physician. On 11/12/24 at 1320 hours, a telephone interview was conducted with LVN 3. LVN 3 stated she had very little time to give the medications. The medications might had been given but not documented. LVN 3 stated she could not prove the medications were given because they were not initialed in the MAR. LVN 3 further stated if the resident refused the medications, she would document of the resident's refusal and inform the RN supervisor or the desk nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1414 hours, a telephone interview with LVN 4 was conducted. LVN 4 confirmed she worked as the desk nurse on 10/20/24. LVN 4 stated when she administered medication, she would pour the medications as scheduled, give the medications to the resident, then document the medications as administered. LVN 4 stated she did not receive any report on 10/20/24, that Resident 2 refused to take the medication. On 11/12/24 at 1530 hours, an interview was conducted with the DON. The DON acknowledged the above medications were not initialed in the MAR. The DON stated the medication administration should be initialed on the MAR to show the medications were administered to the resident.