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	01/13/2025

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** 47476 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for two of eight sampled residents (Residents 1 and 2). * The facility failed to ensure the necessary care and services were provided timely for Resident 2 who had a fall. Additionally, Resident 1's physician ordered the CBC, CMP, and UA with culture laboratory tests; however, the facility failed to perform these laboratory tests. * The facility failed to complete the neurological assessments following Resident 1's unwitnessed fall on 11/23/24. These failures had the potential for the delay of care provided and poor health outcomes for the residents. Findings: 1. Closed medical record review for Resident 2 was initiated on 1/6/25. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. a. Review of the facility's P&P titled Fall - Clinical Protocol revised 3/2018 under the Assessment and Recognition section, showed the nurse shall assess and document/report the following: vital signs; recent injury; musculoskeletal function, observing for change in normal range of motion, weight bearing; change in condition or level of consciousness; neurological status; pain; frequency and number of falls since last physician visit; precipitating factors, details on how fall occurred; all current medications and all active diagnoses. The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. Fall should be categorized as (a) those that occur while trying to rise from a sitting or lying to an upright position; (b) those that occur while upright and attempting to ambulate; and (c) other circumstances such as sliding out of a chair or rolling from a low bed to the floor. Falls should also be identified as witnessed or unwitnessed events. Under the Cause Identification section, showed for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. (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	Under the Treatment/Management section showed based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Under the Monitoring and Follow-Up section, showed the staff, with the physician's guidance, will follow-up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out of resolved. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/ mental condition and/ or status. The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source. Review of the facility's P&P titled Falls and Fall Risk, Managing, revised 3/2018 showed based on previous evaluations and current data, the staff may identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of Resident 2's plan of care showed a care plan focus dated 11/22/24, addressing Resident 2's risk for falls related to antidepressant medication. The interventions included to monitor for changes in condition affecting risk for falls and notify physician if observed. Review of Resident 2's SBAR Communication Form dated 12/24/24 at 1431 hours, showed Resident 2 sustained a fall and was seen by a CNA to slide down from the wheelchair in the hallway due to seat cushion slipping forward, did not sustain a head injury, no bodily harm was noted, and no complaints of pain or discomfort. The primary care clinician was notified and recommended neuro checks. Review of Resident 2's Nurse's Note dated 12/26/24 at 2146 hours, written by LVN 1 showed one fall noted this shift; no injuries noted; vital signs within normal limit; resident assisted back to bed and educated on importance of call light use. Further review of the medical records showed no documented evidence an assessment of Resident 2 was completed regarding the documented fall on 12/26/24. There was no documented evidence the physician and/or resident's representative were notified of the incident. There was no documentation to show the actual time when Resident 2 was found on the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Alert Charting note dated 12/28/24 at 1710 hours, showed during rounds around 1630 Resident 2 was found on the floor mat lying on his back. Asked Resident 2 what happened, Resident stated I'm trying to turn to my side and slid off. Resident alert to name and place, denies pain or discomfort noted. Assessment done, no bruise, and no bump noted. Assisted the resident back to the bed with three persons and made comfortable. The Physician was notified and obtained new order to do CBC, CMP, and neuro checks for 72 hours. Noted and carried out orders. Responsible party was made aware and agreeable. Further review of Resident 2's plan of care showed a care plan focus dated 12/28/24, addressing Resident 2's unwitnessed fall and was at risk for injury, recurring falls. However, Resident 2's care plan was not updated to reflect the falls which occurred on 12/24/24 and 12/26/24. On 1/8/25 at 1439 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON stated she was not sure what was meant when LVN 1 wrote the Nurse's Note dated 12/26/24 and would need to follow up with LVN 1. The DON stated their process when a resident falls, would be to do a change of condition evaluation, notify the physician and the resident's family, update the care plan with what the physician's orders, and 72-hour monitoring. The DON stated the MDS Coordinator or desk nurse would update the care plan regarding the fall. The DON verified Resident 2's care plan was not updated to address Resident 2's falls on 12/24/24 or 12/26/24. On 1/8/25 at 1620 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 2 was a risk for falls. LVN 1 stated on 12/26/24, Resident 2 had an incident with her towards the end of her shift at 2030-2100 hours. LVN 1 stated Resident 2 was on a low-air-loss mattress, slid off the mattress, and was found sitting on his bottom on the floor. LVN 1 stated there were already CNAs in the room to see if Resident 2 was okay and they waited for her to come and see the resident. LVN 1 stated she then took his vital signs, assessed him for injuries, and assisted him back to bed. LVN 1 verified she did not conduct a new change of condition evaluation because Resident 2 was already being monitored for the fall occurring on 12/24/24. LVN 1 stated there was no other change of condition noted, no injuries or vital signs change; and if anything further needed to be done then she would have taken the steps per their facility's protocol. On 1/8/25 at 1626 hours, the DON was informed of and acknowledged the findings. The DON verified LVN 1 should go through the facility's protocol for falls. b. Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2020, showed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. Closed medical record review for Resident 2 was initiated on 1/6/25. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 2's SBAR Communication Form dated 12/24/24 at 1431 hours, showed Resident 2 had a change in condition. Resident 2 was noted to be mumbling words and restless. Resident 2's physician was noted and ordered a CBC, CMP, and UA and urine culture. All orders were placed and carried out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Order Summary Report dated 1/8/25, showed the following completed physician's orders dated: - 12/25/24, for CBC, CMP; and - 12/25/24, for UA and urine culture. Review of Resident 2's medical record failed to show Resident 2's CBC, CMP, and UA and urine culture was obtained as ordered by the physician on 12/25/24. On 1/8/25 at 1439 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked to show documentation Resident 2 had a CBC, CMP, and UA and urine culture laboratory tests drawn as ordered by the physician in 12/25/24. The DON reviewed Resident 2's medical record and was unable to locate documented evidence Resident 2's laboratory tests had been obtained in accordance with the physician's order. 2. Medical record review for Resident 1 was initiated on 1/6/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/10/24, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report dated 1/14/25, showed the following physician orders: - dated 10/28/24, to provide a 1:1 sitter (one resident: one staff) and - dated 11/24/24, for neuro check for 72 hours every shift, status post unwitnessed fall for three days Review of Resident 1's SBAR Communication Form dated 11/23/24, showed Resident 1 had a change in condition related to a fall. Resident 1 was noted to fall out of the geri-chair to the ground. The caregiver was in the restroom at the time of the fall and did not notify the staff he was leaving the resident. Resident 1 was found on the floor facing down, noted skin tears on bilateral elbows and left palm. Resident 1's physician was notified and recommended to send the resident to the acute care hospital for further evaluation. Further review of Resident 1's medical record showed he returned to the facility on [DATE]. There was no documented evidence the neuro checks were completed for 72 hours after Resident 1's unwitnessed fall. On 1/7/25 at 1159 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 stated Resident 1 had a 1:1 sitter and could try to get up by himself but was not stable. LVN 2 stated Resident 1 required assistance to get out of bed and for activities of daily living. LVN 2 stated post-fall, monitoring for the resident would be done for 72 hours and would complete neuro checks if they were not sure if the resident hit their head/unwitnessed fall or if the physician ordered it. LVN 2 verified there was no documented evidence a neuro check was completed for Resident 1's fall on 11/23/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 1328 hours, a concurrent interview and medical record review was conducted with the DON. The DON reviewed Resident 1's medical record and stated Resident 1 came back to the facility within a few hours after being sent to the acute care hospital. The DON verified there was no neuro check completed after Resident 1's unwitnessed fall on 11/23/24.

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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** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of eight sampled residents (Residents 1 and 8) were free from unnecessary psychotropic drugs. * Resident 1, who had diagnoses including dementia, was prescribed lorazepam (antianxiety medication) PRN for anxiety manifested by restlessness. There was no documented diagnosis, or diagnosis of anxiety prior to starting the PRN lorazepam medication. Additionally, Resident 1's physician's orders for the lorazepam medication were continuously renewed PRN for 14 days and eventually extended to be given PRN for 30 days. There was no documented evidence of the evaluation for the renewal of the PRN lorazepam medication order nor rationale from the prescribing practitioner to indicate why it was appropriate for the PRN lorazepam medication order to be extended beyond 14 days. * Resident 8, who had diagnoses including dementia, was prescribed risperidone (antipsychotic medication) for psychosis manifested by inconsolable episodes of calling out. There was no documented diagnosis of psychosis prior to starting the risperidone medication. These failures had the potential to place the residents at risk for receiving unnecessary medications and increased risk of serious medication adverse reactions. Findings: 1. Medical record review for Resident 1 was initiated on 1/6/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1's H&P examination dated 8/30/24, showed Resident 1 had no capacity to understand and make decisions. The H&P examination failed to show a diagnosis of anxiety for the use of the PRN lorazepam medication. Review of Resident 1's H&P examination from the acute care hospital dated 9/6/24, showed Resident 1 had a past medical history of anxiety. Further review of Resident 1's medical record failed to show a documented diagnosis of anxiety prior to 9/6/24. Review of Resident 1's Order Summary Report, dated 1/14/25, showed the following physician's orders: - dated 8/31/24 and discontinued on 9/14/24, for lorazepam oral tablet two mg, give one tablet by mouth every four hours PRN for restlessness for 14 days; - dated 9/5/24 and discontinued on 9/19/24, for lorazepam oral tablet 0.5 mg, give 0.5 mg by mouth every six hours PRN for anxiety manifested by increased restlessness for 14 days; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/10/24 and completed on 9/24/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 14 days manifested by restlessness; - dated 9/25/24 and completed on 10/9/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 14 days manifested by restlessness; - dated 10/11/24 and completed on 10/25/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 14 days manifested by restlessness; - dated 10/25/24 and completed on 11/8/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 14 days manifested by restlessness; - dated 11/11/24 and completed on 11/25/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 14 days manifested by restlessness; - dated 11/26/24 and completed on 12/26/24, for lorazepam oral tablet 0.5 mg, give one tablet by mouth every six hours PRN for anxiety for 30 days manifested by increased restlessness; - dated 12/6/24 and completed on 12/20/24, for lorazepam solution 2mg/ ml, inject 0.5 mg intramuscularly every 12 hours PRN for agitation/restlessness for 14 days; and - dated 12/26/24, to be completed on 1/25/25, for lorazepam oral tablet one mg, give one tablet by mouth every six hours PRN for anxiety for 30 days manifested by increased restlessness. Review of Resident 1's Psychiatric Note dated 12/26/24, showed a plan for Resident 1 to be started on Seroquel (quetiapine fumarate, an antipsychotic medication) medication and to continue the lorazepam medication. Further review of Resident 1's medical record failed to show documented evidence of the justification and clinical indication regarding why Resident 1's PRN lorazepam medication orders were continuously renewed after completed. Additionally, Resident 1's medical record failed to show documented evidence of a clinical rationale for the PRN lorazepam medication order to be extended beyond 14 days to 30 days from 11/26/24 to 12/26/24 and 12/26/24 to 1/25/25. On 1/6/25 at 1212 hours, 1/6/25 at 1229 hours, 1/6/25 at 1240 hours, 1/6/25 at 1256 hours, 1/6/25 at 1313 hours, 1/6/25 at 1321 hours, Resident 1 was observed laying in bed sleeping. Resident 1's lunch tray was observed on his bedside table, untouched. On 1/6/25 at 1321 hours, a concurrent observation and interview was conducted with CNA 1. CNA 1 stated Resident 1 had been asleep since 1000 hours. CNA 1 stated Resident 1 was agitated this morning, and the nurse gave him medications which may have calmed him down too much. CNA 1 stated Resident 1 was a high fall risk, a danger to himself, and was not stable. On 1/7/25 at 0845 hours, a concurrent observation and interview was conducted with CNA 3. CNA 3 stated Resident 1 was very aggressive and would think he was breaking into his house. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 1159 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 was not able to provide documented evidence showing Resident 1 was diagnosed with anxiety and would need to clarify with the physician. LVN 2 stated for the PRN orders for the use of the psychotropic drugs, before 14 days the resident would need to be reevaluated and if the resident did benefitedfrom the medication, we would notify the physicianthen extend the order for 30 or 60 days. LVN 2 verified there was no documented evidence of appropriateness for Resident 1's PRN lorazepam medication order to be extended beyond 14 days. On 1/7/25 at 1515 hours, a follow up interview was conducted with CNA 1. CNA 1 stated Resident 1 woke up around 1450 hours the day prior. CNA 1 stated Resident 1 was normally confused and could get aggressive. On 1/8/25 at 0910 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated Resident 1 was taking the lorazepam medication for restlessness because he was anxious. The DON verified there was no documented evidence of a diagnosis of anxiety prior to Resident 1 being starting the PRN lorazepam medication. The DON verified there was no documented evidence the physician had evaluated Resident 1 for the appropriateness of the renewal of the PRN lorazepam medication orders nor documented clinical rational to extend the PRN lorazepam medication orders beyond 14 days. 2. Review of the FDA black box warning for prescribing risperidone showed elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis. Medical record review for Resident 8 was initiated on 1/7/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 9/10/24, showed Resident 1 had no capacity to understand and make decisions. The H&P examination failed to show a diagnosis of psychosis for the use of the risperidone medication. Review of Resident 8's Order Summary Report, dated 1/14/25, showed a physician's order dated 12/10/24 for risperidone oral tablet 0.25 mg, give one tablet by mouth one time a day for psychosis manifested by inconsolable episodes of calling out. Review of Resident 8's Psychiatric Note dated 12/26/24 showed Resident 8 was diagnosed with psychosis and a plan to increase Resident 8's risperidone to 0.25 mg three times a day. On 1/6/25 at 1321 hours, a concurrent observation and interview was conducted with CNA 1. Resident 8 was observed laying down in bed and attempting to get up out of bed by himself. An audible bed alarm is heard when Resident 8 starts to stand up. CNA 1 was observed to redirect Resident 8 back to bed. CNA 1 stated Resident 8 was a fall risk. On 1/7/25 at 0845 hours, a concurrent observation and interview was conducted with CNA 3. CNA 3 stated Resident 8 could walk by himself, would wander, and was very aggressive. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 1530 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 8 was not diagnosed with psychosis in the acute care hospital prior to being admitted to the facility. RN 1 stated she was not sure where Resident 8's diagnosis of psychosis came from and could not provide documented evidence of when and who diagnosed Resident 8 with psychosis. On 1/7/25 at 1629 hours, a concurrent interview and medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified she inputted Resident 8's medical diagnoses into their electronic medical records system. When asked where she found Resident 8's diagnosis of psychosis, the MDS stated she did not see a diagnosis of psychosis on Resident 8's medical record other than on Resident 8's physician's orders for the risperidone medication. On 1/8/25 at 1439 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of and acknowledged the above findings.