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	01/31/2025

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

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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 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, 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 when the facility failed to report an allegation of resident-to-resident abuse to the CDPH, L&C Program and to the local ombudsman for one of the nine sampled residents (Resident 5). This failure had the abuse allegation going unreported and uninvestigated. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022 showed all the reports of the resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Closed medical record review for Resident 5 was initiated on 1/31/25. Resident 5 was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 5's H&P examination dated 7/16/22, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's Progress Notes showed an entry dated 7/31/24, by the SSD. The SSD documented Resident 5 was verbally abusive to the roommate. Resident 5 was threatening the roommate the whole night. The roommate was scared Resident 5 might do something. The Administrator was aware of the situation and called the physician. On 1/31/25 at 1452 hours, an interview was conducted with the DON. The DON verified the allegation of the resident-to-resident abuse was not reported to CDPH, L&C program ombudsman or to the police. On 1/31/25 at 1615 hours, an interview was conducted with the Administrator. The Administrator acknowledged the facility did not report aforementioned resident-to-resident abuse allegation.

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 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 resident-to-resident abuse for one of nine sampled residents (Resident 5). * The facility failed to conduct a thorough investigation when Resident 5 was reported to be verbally abusive to the roommate. This failure posed a risk for the resident to not be protected against the alleged abuse and placed other vulnerable residents at risk for abuse. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022 showed all the allegations are thoroughly investigated. The Administrator initiates the investigations. Within five business days of the incident, the Administrator will provide a follow-up investigation report. Closed medical record review for Resident 5 was initiated on 1/31/25. Resident 5 was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 5's H&P examination dated 7/16/22, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's Progress Note showed an entry dated 7/31/24, by the SSD. The SSD documented Resident 5 was verbally abusive to the roommate. Resident 5 was threatening the roommate the whole night. The roommate was scared Resident 5 might do something. The Administrator was aware of the situation and called the physician. On 1/31/25 at 1452 hours, an interview was conducted with the DON. The DON verifiedthe facility did not do an investigation regarding the resident-to-resident abuse allegation. On 1/31/25 at 1615 hours, an interview was conducted with the Administrator. The Administrator acknowledged the facility did not conduct an investigation regarding the aforementioned resident-to-resident abuse allegation. Cross reference to F609.

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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 nine sampled residents (Resident 1) was free from the unnecessary psychotropic medications. * The facility failed to obtain the informed consent from Resident 1 or surrogate decision maker for the use of lorazepam (a drug used to relieve anxiety) and when there was an increase in the dosage of the citalopram (a drug used to treat depression) medication. * The facility failed to ensure Resident 1 was provided with the non-pharmacologic interventions for the use of the citalopram, quetiapine fumarate (a drug that can treat schizophrenia, bipolar disorder and depression), and buspirone (a drug used to treat anxiety) medications. These failures have the potential to negatively affect Resident 1's well-being. Findings: Medical record review for Resident 1 was initiated on 1/29/25. Resident was admitted to the facility on [DATE] and readmitted on [DATE]. a. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 12/19/24, for buspirone 5 mg three times a day for anxiety manifested by verbalization of feeling anxious, citalopram 30 mg one time a day for depression manifested by episodes of crying, and quetiapine fumarate 25 mg one tablet at bedtime for episodes of yelling outbursts leading to exhaustion; and - dated1/12/25, for lorazepam 0.5 mg every twelve hours as needed for anxiety manifested by restlessness for fourteen days or until 1/26/25. Review of Resident 1's Informed Consent - Psychoactive Medication showed an informed consent was obtained from the surrogate decision maker for the following medications: - on 4/11/24, for the use of the buspirone 5 mg for anxiety manifested by verbalization of anxiety, citalopram 20 mg for depression manifested by verbalization of feeling sad, and lorazepam 0.5 mg every six hours as needed for verbalization of feeling anxious; and - on 8/23/24, for the use of the Seroquel (quetiapine fumarate) 50 mg for psychosis manifested by inconsolable episodes of crying out. However, there was no documentation of an informed consent obtained from Resident 1 or surrogate decision maker for the increase in the dosage of the citalopram and when the lorazepam medication order was renewed on 1/12/25. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of the facility's P&P titled Antipsychotic Medication Use revised 7/2022 showed the residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situations. For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are not sufficiently relieved by non-pharmacologic interventions. Review of Resident 1's MAR for January 2025 showed Resident 1 had the following physician's order and was administered the following medications: - buspirone 5 mg three times a day for anxiety daily from 1/1 to 1/29/25; - citalopram 30 mg one time a day for depression daily from 1/1 to 1/29/25; - quetiapine fumarate 25 mg one tablet at bedtime for episodes of yelling outbursts leading to exhaustion daily from 1/1 to 1/29/25; and - lorazepam 0.5 mg every 12 hours as needed for fourteen days manifested by yelling out on 1/26/25 at 1742 hours. Review of Resident 1's medical record failed to show documented evidence Resident 1 was provided with the non-pharmacologic interventions for the psychotropic medications use. On 1/30/25 at 1043 hours, a concurrent interview and medical record review was conducted with LVN 9. LVN 9 stated Resident 1 was on routine buspirone, citalopram, and quetiapine medications; and as needed lorazepam medication. LVN 9 was asked if there was an informed consent on Resident 1's increased in the dosage of the citalopram medication and for the new order of as needed lorazepam medication. LVN 9 was unable to provide documentation. Furthermore, LVN 9 was asked if there was any non-pharmacologic intervention provided to Resident 1, LVN 9 was unable to provide documentation. On 1/31/25 at 1452 hours, a concurrent interview and medical record review was conducted with the DON. The DON confirmed there were no informed consent obtained from Resident 1 or surrogate decision maker for the use of as needed lorazepam medication or increased dosage of the citalopram medication. The DON also confirmed there was no documentation of the non-pharmacological interventions provided to Resident 1 for the use of the psychotropic medications. The Administrator was made aware and acknowledged the above findings.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **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 the resident's food preferences and allergies were considered and adhered to for one of nine sampled residents (Resident 4). * The facility failed to ensure Resident 4 was not served food containing fish as Resident 4 was allergic to fish. This failure caused an adverse reaction on Resident 4's well-being. Findings: Review of the facility's P&P titled Tray Identification revised 4/2007 showed the appropriate identification/coding shall be used to identify various diets. To assist in setting up and serving the correct food trays/diets to residents, the food services department will use appropriate identification (example color coded or computer-generated diet cards) to identify the various diets. The food services manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. The nursing staff check each food tray for the correct diet before serving the residents. If there is an error, the nurse supervisor will notify the dietary department immediately by phone so that the appropriate food tray can be served. Medical record review was initiated for Resident 4 on 1/29/25. Resident 4 was admitted to the facility on [DATE]. Resident 4 was allergic to fish. Review of Resident 4' s H&P examination dated 1/15/25, showed Resident 4 hadthe capacity to understand and make decisions. Review of Resident 4's Plan of Care initiated and revised on 1/15/25, showed a care plan problem addressing the risk for an allergic reaction due to food allergy to fish. On 1/30/25 at 1605 hours, an interview and concurrent facility document review was conducted with the DSS. Review of the facility's menu for 1/13 to 1/19/25, showed grilled chicken breast on a bun for dinner on 1/19/25. Further review of the document showed the grilled chicken was stroked-out and breaded fish was written on top of the grilled chicken with initials. The DSS verified the menu had changed to breaded fish. The DSS stated he put his initial when the menu had changed. Review of Resident 4's Progress Note on 1/19/25 at 1815 hours, showed the residenthad an episode of allergic reaction to fish dueto consuming fish which was served as sandwich protein. The resident's allergy to fish was established and documented. The resident's dinner slip showed the grilled chicken as the protein in the sandwich. The notes also showed the inability to correctly identify the sandwich protein as fish during inspection of trays prior to having patients be served, arose from the fact the fish was shredded and mixed with other ingredients/condiments. The notes further showed the LVN's documentation stating for the food content identification, I relied entirely on the dinner slip which showed grilled chicken. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Progress Note on 1/19/25 at 1830 hours, showed Resident 4 was served a fish sandwich on the dinner tray. Per the resident, I took a bite out of the sandwich, when my throat and neck started to feel heavy. That is when I realized that I took a bite out of a fish sandwich. The notes further showed the physician was notified and ordered to transfer Resident 4 to the acute care hospital via 911. Review of Resident 4' SBAR Communication Form dated 1/19/25, showed at 1830 hours, Resident 4 was served a fish sandwich on the dinner tray and had an allergy to fish. Resident 4 was transferred out via 911 to the acute care hospital. Review of Resident 4's Emergency Department Provider Note dated 1/19/25, Resident 4 was brought to the emergency department because of possible allergic reaction after eating fish at dinner. Resident 4 got anxious and felt warm all over. Resident 4's After Visit Summary dated 1/19/25, showed the anxiety and allergic reaction were the reasons for the visit. Further review of the Emergency Department Provider Note showed the differential diagnosis included allergic reaction, anxiety/panic attack, generalized pain/chronic pain among other entities. On 1/29/25 at 1510 hours, an interview was conducted with Resident 4. Resident 4 was asked for his allergies, and he stated fish. Resident 4 stated the facility thought a chicken sandwich was served but a fish sandwich was served instead. Furthermore, Resident 4 stated after taking a bite or two of the sandwich he felt he could not breath and felt heavy on the throat. On 1/30/25 at 1446 and 1605 hours, a concurrent interview and facility document review was conducted with the DSS. The DSS stated on admission, the resident was asked about likes/dislikes and allergies. The nursing staff member checked each of the food tray if it was correct before serving to the residents. The DSS was asked why the grilled chicken was stroked out from the dinner menu on 1/19/25, the DSS stated on 1/17/25, the vendor was out of grilled chicken, so the menu was changed to breaded fish. Furthermore, the DSS verifiedthe change in the menu had been communicated to the nursing staff. On 1/31/25 at 1408 hours, an interview was conducted with RN 1. RN 1 stated during the meal distribution, the nursing staff had compared the meal ticket with the diet list and lift the lid of the meal tray to confirm if the meal was the same with the meal ticket. The meal ticket included the resident's likes, dislikes, and allergies. If there was a change in the menu, the DSS communicated the changes to the nursing staff. On 1/31/25 at 1452 hours, an interview was conducted with the DON. The DON stated the medications could not be placed in the PCC if the allergy section was not filled out. The DON was asked about the process for tray distribution, the DON stated the licensed nurse would have a diet printout to match the diet slip. The licensed nurse opened the meal tray to confirmed if the tray had the right diet. If there were changes in the menu, it would be communicated by the DSS at the 0930 hours meeting with all the department heads. The changeswould also be communicated to the nursing staff.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48844 Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's environmental conditions were kept sanitary as evidenced by: * The toilet/bathroom shared by Rooms A and B was observed with several used washcloths and a yellow and pink pitcher by the sink with no label. * The Dirty laundry collection rolling bin was observed to be with brown colored residue located on the top corner of the bin and was observed to be touched with bare hands several times by the facility staff member while pushing the bin. These failures posed the risk of unsanitary and unsafe conditions for the residents, staff, and visitors. Findings: 1. Review of the facility's P&P titled Homelike Environment revised on 2/2021 showed the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. On 1/29/25 at 1500 hours, an observation of the toilet/bathroom shared by Rooms A and B was conducted with RN 3. The toilet was observed with the following: - used washcloths by the sink, on top of the paper towel dispenser and hanging at the toilet seat lid; and - a yellow and pink pitcher with no label by the sink. RN 3 stated the CNA should have collected the used washclothsand placed in the dirty linen. The pitcher should always be labeled and should not be in the toilet. RN 3 acknowledged the used items in the toilet/bathroom can be accidentally used by another resident. On 1/31/25 at 1615 hours, the Administrator and DON were made aware and acknowledged the above findings. 2. Review of the facility's P&P titled Laundry and Bedding, Soiled revised on 9/2022 showed the linen carts are cleaned and disinfected whenever visibly soiled and according to the established schedule. Separate carts are used for transporting clean and contaminated linen. Otherwise, carts that are used for transport of dirty linen are thoroughly cleaned and disinfected before being used to transport clean linen. (continued on next page)

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/31/25 at 0900 hours, an observation was conducted atStation 1 hallway. A dirty laundry collection rolling bin was observed with brown residue on the top corner of the bin. The bin was located across the Administrator's office. On 1/31/25 at 1035 hours, a concurrent interview and observation was conducted with CNA 2. CNA 2 was observed to be pushing the dirty laundry collection rolling bin with bare hands near Station 1 hallway. The bin was still observed to have brown colored residue on the top corner and CNA 2 was observed touching the brown colored residue many times while pushing the bin. CNA 2 was asked what could be the brown colored residue found on top of the corner of the bin. CNA 2 stated that it could be a bowel movement stain from a dirty linen. The CNA 2 further stated the bin should have beencleaned and gloves should be worn to prevent spread of infection and to maintain good hygiene and sanitation of the bin. On 1/31/25 at 1449 hours, an interview was conducted with the DON. The DON stated the bin should have been cleaned and CNA should have worn gloves at least to maintain good hygiene and sanitation of the dirty laundry bin and to prevent the spread of infection.