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	09/18/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary treatment and services for the provision of parenteral fluids (liquids administered to the body, most commonly via a vein (intravenous, to provide hydration, correct the electrolyte imbalances, deliver nutrients, or administer the medications when normal oral intake is not possible) for one of six sampled residents (Resident 1). * The facility failed to ensure Resident 1's intravenous fluids (IVF) was administered and documented as per the facility's P&P. This failure had the potential to negatively affect Resident 1's health and well-being. Findings: Review of the facility's P&P titled Intravenous Administration of Fluids and Electrolytes dated 2001 showed the resident should be monitored frequently, per facility policy, when continuous fluids are infusing for signs and symptoms of fluid overload, catheter patency, insertion site complications, and resident's tolerance of procedure. The following information should be recorded in the resident's medical record including: 1. The date and time the infusion was administered;2. The type of solution administered;3. The amount of solution administered;4. The route of administration;5. The rate of administration;6. The condition of the IV site before and after administration;7. Notification of the provider if there are any complications;8. How the resident tolerated the procedure; and9. The signature and title of the person recording the data. The P&P further showed to notify the provider, supervisor, and on the coming shift of complications or resident refusal of treatment. Report other information in accordance with facility policy and professional standards of practice. Medical record review for Resident 1 was initiated on 9/3/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's progress note dated 9/5/25 at 1315 hours, showed LVN 4 received a new physician's order for STAT labs and IVF NS (normal saline) at 75 ml per hour until labs get back. LVN 4 documented the orders were noted and carried out. However, further review of Resident 1's progress notes failed to show documented evidence the IVF was administered to Resident 1. The progress notes also failed to show if the physician was notified if the IVF was not administered. Review of Resident 1's MAR for September 2025 showed the following physician's order dated 9/5/25 at 2021 hours:- may call IV Experts for IV insertion due to poor venous access; and - to transfer Resident 1 out to Acute Hospital A for further evaluation of decreased urine output and increased lethargy (state of extreme tiredness, lack of energy, and sluggishness). Review of Resident 1's Order Summary Report and MAR for September 2025 failed to show a physician's order for the normal saline IVF ordered on 9/5/25 at 1315 hours. On 9/18/25 at 1550 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified the above findings. When asked if the normal saline IVF was documented on the MAR, RN 2 verified there was no documented evidence the IVF and/or the IV site monitoring were noted on the resident's MAR. RN 2 stated she recalled being able to insert a peripheral IV on Resident 1's left thumb area on 9/5/25 at approximately 1400 hours and starting the IVF. However, RN 2 verified there was no documented evidence to show the IV peripheral was inserted and the IVF was administered as ordered by the physician. On 9/18/25 at 1630 hours, an observation and concurrent interview was conducted with RN 2. When asked to show documented evidence the normal saline IVF was removed from the facility's IV E-kit and administered to Resident 1 on 9/5/15, RN 2 stated she had to check the facility's medication rooms for the record. RN 2 stated the facility had two nursing stations and the protocol for removing medications from the E-kit would be to complete a form and place the copy of the completed form in the E-kit and another copy would be kept at the facility. After observations of both nursing stations were conducted with RN 2, RN 2 verified there was no documented evidence a form was completed to show the normal saline IVF was removed from the E-kit on 9/5/25 for Resident 1. On 9/18/25 at 1712 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. On 9/19/25 at 1219 hours, a telephone interview was conducted with the IV Department Supervisor at Pharmacy A stated there was no documented evidence a form was completed by the facility staff to show the normal saline IVF was removed from the facility's IV E-kit for Resident 1 on 9/5/25. The IV Department Supervisor at Pharmacy A stated the process when the facility staff removed an IV medication from the IV E-kit would be to complete the form. A copy of the complete form would be kept in the E-kit and another copy would stay in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage of the medications for one of six sampled residents (Resident 2). * The facility failed to ensure Resident 2 had no medication stored at the bedside. This failure had the potential for Resident 2 to administer the medication inaccurately.Findings: Review of the facility's P&P titled Self-Administration of Medications revised 2/2021 showed any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. On [DATE] at 0941 hours, an observation was made in Resident 2's room. One tube of diclofenac sodium 1% topical gel (medication that treats arthritis/osteoarthritis) was observed on the top drawer of Resident 2's bedside drawer with a fill date of [DATE], and had expired on 11/2023. Resident 2 was observed to be in the room. Medical record review for Resident 2 was initiated on [DATE]. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated [DATE], showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Nursing - Self-Administration of Mediation Observation dated [DATE], showed Resident 2 did not want to self-administer medications. Review of Resident 2's Order Summary Report dated [DATE], showed no physician's order for the diclofenac sodium 1% topical gel (pain medication). Further review of Resident 2's medical record failed to show documentation Resident 2 could store the diclofenac medication at the bedside. On [DATE] at 0945 hours, an observation, interview, and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 reviewed Resident 2's medical record and verified there was no physician's order or care plan allowing the resident to store the medications at the bedside. RN 1 verified Resident 2's Self-Administration of Medication assessment dated [DATE], showed the resident did not want to self-administer the medications. RN 1 stated the resident's family member may have brought in the medication and the facility would contact the family. RN 1 further stated the medication needed a physician's order prior to administering the medication and should not be left unattended at the resident's bedside because the facility staff would not be able to assess for proper administration of the medication by the resident. On [DATE] at 1029 hours, an interview with Resident 2 was conducted with RN 1 and CNA 4 present. Resident 1 requested CNA 4 to translate in Vietnamese. Resident 2 stated the diclofenac medication was provided by her family. When Resident 2 was asked when the diclofenac medication was brought in by her family, Resident 2 stated she did not recall. On [DATE] at 1135 hours, an interview was conducted with the DON. The DON stated the medications could be left at the resident's bedside if there was a physician's order, care plan, and an evaluation to self-administration the medications. The DON stated the other residents or facility staff could use the medication not intended for their use, if the medication was left unattended at the resident's bedside. On [DATE] at 1712 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the laboratory tests for one of six sampled residents (Resident 1) was performed as ordered. * The facility failed to ensure Resident 1's physician's order for stat CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) were completed as ordered. This failure posed the risk for Resident 1 not receiving the appropriate treatment, which could significantly impact the resident's well-being.Findings: Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol revised 11/2018 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. The laboratory, diagnostic radiology provider, or other testing sources will report test results to the facility. The P&P further showed a nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition. The P&P further showed the nurse will try to determine whether the test was done to assess a condition change or recent onset of signs and symptoms. Moreover, the P&P showed the nursing staff will consider the following factors to help identify situations requiring prompt physician notification concern lab or diagnostic test results: - Whether the physician has requested to be notified as soon as a result is received.- Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors).- Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison. Medical record review for Resident 1 was initiated on 9/3/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report for September 2025 showed the following physician's orders:- dated 9/5/25 at 1315 hours, for stat CBC and CMP. - dated 9/5/25 at 2021 hours, to transfer the resident to Acute Hospital A for further evaluation of the decreased urine output and increased lethargy. Review of Resident 1's medical record failed to show documented evidence Resident 1's physician's order for stat CBC and CMP were completed. On 9/17/25 at 1607 hours, an interview was conducted with LVN 2. LVN 2 stated stat laboratory orders should be done as soon as possible, typically within two hours. LVN 2 stated it was also depended on when the laboratory technician arrived at the facility. LVN 2 stated if the physician's order was ordered as stat and the laboratory tests were not drawn at a certain time or if the laboratory technician could not make it to the facility stat, then she would notify the physician and document in the resident's medical record. In addition, LVN 2 stated for stat laboratory orders, the facility had to enter the physician's order into the facility's PCC (Point Click Care) system and laboratory's portal system and also call the laboratory to inform them of the stat order. On 9/18/25 at 1135 hours, an interview was conducted with the DON. The DON stated stat laboratory tests were done in a ‘timely manner, with no specific time; however, the DON stated the laboratory company would say the best practice is four hours. The DON further stated if the laboratory would take an extended time to draw the specimen, she expected the licensed nurses to call and follow up with the laboratory to determine the estimated time the laboratory technician would arrive. The DON stated she also expected the licensed nurses to document the follow up with the laboratory and physician if the laboratory would not be able to complete the ordered tests as stat. On 9/18/25 at 1437 hours, a telephone interview was conducted with the Hospital Lab Assistant. The Hospital Lab Assistant stated stat laboratory tests were done within two to four hours but also depended on the technician's availability in the area. The Hospital Lab Assistant stated to process stat laboratory orders, the facility needed to also call the laboratory company to inform them of the stat laboratory order. When asked if the laboratory received a stat order for Resident 1, the Hospital Lab Assistant stated they did not and stated the last blood work was completed on 8/22/25. On 9/18/25 at 1515 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 verified he received the physician's orders for Resident 1's stat CBC and CMP on 9/5/25 at 1315 hours. LVN 4 verified the laboratory portal did not show the stat laboratory results for Resident 1. When asked if he saw the laboratory technician arrive after the stat laboratory was ordered, LVN 4 stated he did not see the laboratory technician prior to the end of his shift on 9/5/25. On 9/18/25 at 1712 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of six sampled residents (Resident 1) was complete. * The facility failed to ensure Resident 1's TAR for August 2025 was complete regarding the monitoring of the resident's urine characteristics. This failure had the potential to result in inadequate care due to an incomplete medical record for Resident 1. Findings: Review of the facility's P&P titled Catheter Care, Urinary revised 5/2024 showed the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The P&P further showed information should be recorded in the resident's medical record including character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. Medical record review for Resident 1 was initiated on 9/3/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 8/13/25, for Resident 1's Foley catheter size16 Fr 10 ml and to change as needed. Review of Resident 1's TAR for August 2025 showed a physician's order dated 8/14/25, for the indwelling urinary catheter and to monitor for change in the urine character. However, the TAR was blank on 8/15/25 for the evening shift and 8/22/25 for the night shift. On 9/18/25 at 1400 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated when the TAR was left blank, it meant it was not documented. LVN 3 stated the monitoring for the change in the urine character should have been documented if it was completed. On 9/18/25 at 1532 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the licensed nurse might have monitored for the resident's urine characteristics for the evening shift on 8/15/25, and on the night shift on 8/22/25, but might have forgotten to document on the resident's TAR. LVN 5 stated it should have been documented if it the monitoring was done as ordered. On 9/18/25 at 1712 hours, an interview was conducted with the Administrator and DON. The DON stated she expected the licensed nurses to follow the physician's orders. The Administrator and DON were informed and acknowledged the above findings.