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	02/05/2026

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 - 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** Based on interview, medical record review and facility P&P review, the facility failed to provide the necessary skilled nursing care and services for four of eight sampled residents (Residents 1, 3, 4, and 7). * The facility failed to provide continued life-saving measures to Resident 7 when the resident remained unconscious, barely breathing and did not have any blood pressure reading and until the paramedics arrived. This failure resulted to interrupted chest compressions and rescue breathing in an arrest resuscitation and potentially contributed to the resident's death in the acute hospital. * The facility failed to timely and accurately complete a hip/femur x-ray as recommended by the physical therapist due to Resident 1's consistent right hip pain. In addition, the facility failed to obtain a urine sample for testing as ordered by the physician and notify the physician when Resident 1 had an abnormal hemoglobin result. These failures had the potential for the delay in the identification of problems and provision of the necessary interventions which could negatively impact the resident's well-being. * The facility failed to provide Residents 1, 3 and 4 the wound care treatment as ordered by the physician. These failures had the potential to negatively impact Residents 1, 3, and 4's well-being.Findings: 1. Review of the facility's P&P titled Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support dated 2001 showed the personnel are certified in CPR (Cardiopulmonary resuscitation for healthcare providers and BLS (basic life support), including defibrillation for victims of sudden cardiac arrest. If an individual is found unresponsive and not breathing normally, a staff member who is certified in CPR for health care providers or BLS will administer CPR unless: a. it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/ or external defibrillation exist for that individual; or b. there are obvious signs or irreversible death. According to [NAME] A, Singh B, [NAME] PH. Cardiopulmonary Resuscitation. [Updated 2025 Jun 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan from: National Library of Medicine, retrieved 2/6/26, https://www.ncbi.nlm.nih.gov/books/NBK470402/ chest compressions are the cornerstone of CPR. These compressions generate artificial circulation by increasing intrathoracic pressure, which compresses the heart and propels blood forward. Effective compressions maintain coronary perfusion pressure, which is the difference between aortic diastolic and right atrial diastolic pressure during the relaxation phase of compressions. Coronary perfusion pressure is crucial for myocardial blood flow and is a primary determinant of successful return of spontaneous circulation. Ventilations provide oxygen to the lungs and help maintain blood oxygenation. However, positive-pressure ventilation can reduce coronary perfusion pressure by increasing intrathoracic pressure and impeding venous return to the heart. Therefore, the balance between adequate ventilation and minimizing interruptions to chest compressions is critical. The definitive treatment for ventricular fibrillation and pulseless ventricular tachycardia is electrical defibrillation, most commonly administered using an automated external defibrillator. If defibrillation is not performed promptly, brain death can occur in less (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	than 10 minutes. CPR is a critical intervention to provide artificial circulation and ventilation until defibrillation is possible. When performed correctly, conventional manual CPR can deliver up to 33% of normal cardiac output and oxygenation. The cycle of 30 chest compressions followed by 2 rescue breaths should be continued until an automated external defibrillator becomes available or until additional help arrives. Once an automated external defibrillator is on scene it automatically analyzes the cardiac rhythm and advising whether a shock is necessary. If a shock is advised, chest compressions should be paused, and everyone should stand clear while the automated external defibrillator delivers defibrillation. Immediately after the shock, or if no shock is advised, CPR should be resumed without delay, continuing the CAB (Compressions, Airway, and Breathing) sequence until further assistance or advanced care arrives. According to American Heart Association's Hard Hats with Heart undated, retrieved 2/6/26, https://www.heart.org/-/media/Files/Affiliates/WSA/Oregon/CPR-Frequently-Asked-Questions.pdf showed CPR Frequently Asked Questions Toolbox Talks, the section for When do I stop giving Hands-Only CPR? showed to continue pushing hard and fast in the center of the chest until help arrives. If the person speaks, moves, or breathes normally while you're giving chest compressions, Hands-Only CPR can be stopped. Medical record review for Resident 7 was initiated on 2/4/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 1/29/26, showed the resident had the capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 2/4/26, showed a physician's order dated 1/27/26, for full code. Review of Resident 7's POLST dated 1/27/26, the CPR section indicated to Attempt Resuscitation/CPR and the Medical Interventions section indicated Full Treatment (primary goal of prolonging life by all medically effective means). Review of Resident 7's eInteract SBAR Communication Form and Progress Notes dated 2/2/26, showed Resident 7 was found on the floor next to the bed, with no response to verbal and tactile stimuli, the assessment revealed asystole and absence of respiration, CPR was initiated and 911 was called. After approximately 20 minutes of CPR, return of spontaneous circulation was achieved and assumed care. The note further showed the fire department arrived, continued CPR and lifesaving measured for another 20 minutes. Further review of Resident 7's medical record failed to show a documentation and/or the vital signs reading when the staff achieved spontaneous circulation. Review of the Resident 7's Electronic Patient Care Report from the Fire Department dated 2/2/26 at 0236 hours, showed the fire department arrived on scene to find resident on the ground surrounded by care staff pulseless, apneic and without compressions being performed. The manual compressions was initiated. BVM (Bag-Valve-Mask) with high flow oxygen was administered. Defibrillation pads were applied at 0239 hours, resident was PEA (Pulseless Electrical Activity). Review of Resident 7's Emergency Department H&P examination dated 2/2/26, the Disposition section showed unfortunately the patient passed away in the Emergency Department. On 2/4/26 at 1435 hours, a telephone interview was conducted with the Fire Captain. The Fire Captain stated he arrived at the facility and found Resident 7 on the ground surrounded by care staff, pulseless and not breathing, and without compressions being performed. The Fire Captain further stated the staff informed him of the CPR provided to the resident for twenty minutes and believed the heart rate was back and stopped the compressions. On 2/4/26 at 1611 hours, a telephone interview was conducted with RN 3. RN 3 stated she walked in Resident 7's room with LVN 5 on the scene. RN 3 stated Resident 7 was unresponsive and had no pulse, then LVN 5 and RN 3 initiated CPR immediately. RN 3 stated LVN 5 provided compressions while RN 3 provided breathing with the use of Ambu bag. RN 3 further stated the pulse was achieved prior to the fire department's arrival at the scene. However, RN 3 further stated Resident 7 had no blood pressure and remained unconscious. On 2/4/26 at 1536 hours, a telephone interview was conducted with LVN 4. LVN 4 stated Resident 7 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	was unresponsive and had no pulse, and CPR was initiated immediately. LVN 5 provided the compressions while RN 3 provided breathing with the use of Ambu bag. LVN 4 further stated they provided CPR for twenty minutes then the resident's pulse came back, and RN 3 stated to stop the CPR while waiting for the paramedics. On 2/5/26 at 0617 hours, an interview was conducted with LVN 5. LVN 5 stated he found Resident 7 lying on the floor on the left side halfway on prone position. LVN 5 stated Resident 7 had no pulse oximeter reading and RN 3 verified the resident had no pulse and respiration. LVN 5 stated he provided the compressions while RN 3 provided the breathing with the use of Ambu bag. LVN 5 further stated they had performed CPR for 18-20 minutes then obtained carotid pulse as confirmed by RN 3. LVN 5 stated they stopped the compressions with the presence of carotid pulse. LVN 5 further stated Resident 7 remained unconscious, barely breathing and did not have any blood pressure reading for approximately 5-7 minutes while waiting for the paramedics to arrive. On 2/5/26 at 0850 hours, an interview was conducted with the DON. The DON stated the expectation for the licensed nurses was to continue with the CPR until the fire department arrives and takes over the resuscitation. Cross Reference to F726. 2. Review of Resident 1's medical record was initiated on 1/27/26. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1's H&P examination dated 1/21/26, showed the resident had no capacity to understand and make decision. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's BIMS score was 3 indicating the resident had severe cognitive impairment. The section GG for Functional Abilities showed Resident 1 required total dependence in activities of daily living and mobility. a. Review of Resident 1's eInteract SBAR Communication Form and Progress Notes dated 7/25/25, showed reported from 2 CNAs, attempted to transfer resident from chair to bed, the resident folded legs in the mid transfer and unable to provide full transfer, gradually assisted resident to the floor with no injuries. Review of Resident 1's Care Plan Report showed a focused problem for fall; resident had an assisted fall and is at risk for injury and recurring falls initiated on 7/25/25. The interventions included to monitor for complications related to the fall such as change in neurological status, evidence of injury, loss of range of motion, pain, and to notify the physician promptly if observed. Review of Resident 1's Rehab-Status Post-Fall Screen dated 7/25/25 at 1639 hours, showed the resident had a fall on 7/25/25 at 1100 hours. The note further showed recommending right hip/ femur and knee x-ray due to consistent right hip pain, nursing notified. Positive [NAME] on right hip. Review of Resident 1's IDT - Fall Progress Notes dated 7/29/25 at 1500 hours, showed Resident 1 had fall on 7/25/25 and had no injury. The current intervention showed for the therapy to re-evaluate. Further review of Resident 1's medical record failed to show a documentation if the facility had notified the physician regarding the PT's recommendation for x-ray right hip/femur and knee due to consistent right hip pain with positive [NAME]. Review of Resident's Order Summary Report dated 1/30/26, showed the following physician's orders:- dated 7/22/25, to provide the non-pharmacological intervention for pain prior to administering the pain medication, 1. Back rub, 2. Repositioning, 3. Warm drink, 4. TV/ Music, 5. Ice Pack; 6. None, and- dated 7/29/25, for the bilateral x-ray of hips/femur to knee per DON due to positive [NAME] test with acute pain. Review of Resident 1's MAR for July 2025 showed Resident 1 was provided with the non-pharmacological interventions for pain on the following dates and shifts:- dated 7/26/25, during day shift with 2. Repositioning;- dated 7/26/25, during evening shift with 2. Repositioning;- dated 7/27/25, during day shift with 1. Back rub, 3. Warm drink, 5. Ice Pack;- dated 7/27/25, during night shift with 1. Back rub, 2. Repositioning, 3. Warm drink;- dated 7/28/25, during night shift with 2. Repositioning; and - dated 7/29/25, during night shift with 1. Back rub, 2. Repositioning, 3. Warm drink. Review of Resident 1's Radiology Interpretation dated 7/29/25, for the bilateral hips (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	examination, the finding showed multiple views of the bilateral hips were reviewed and no acute fracture was identified. Further review of Resident 1's medical record failed to show if the x-ray result for the bilateral femur to knees were completed as ordered by the physician. Review of Resident 1's eInteract SBAR Communication Form and Progress Notes dated 8/1/25 at 0800 hours, showed Resident 1 had an order to be transferred to ER possible blood transfusion. Review of Resident 1's Hospitalist H&P dated 8/1/25, showed the resident presented to ER due to concerns of low hemoglobin. While Resident 1 was in Acute Care Hospital A, an x-ray of the right knee due to right knee pain was done on 8/3/25, the findings showed markedly displaced fractures involving the distal femur. Review of Resident 1's Acute Care Hospital B Internal Medicine H&P dated 8/11/25, showed Resident 1 underwent open reduction and internal fixation (ORIF) of the right distal femur on 8/10/25. On 1/27/26 at 1619 hours, a telephone interview was conducted with family member 1. Family Member 1 stated she was informed Resident 1 fell on 7/25/25. Family Member 1 stated she had observed Resident 1 moaned at times when she visited the facility. According to Family Member 1 the resident does not speak as much because of her condition and she did not see any obvious external deformity. Family Member stated the x-ray was done at the facility which showed negative for fracture. Family Member 1 further stated the nurses had reassured her there were no injury. Family Member 1 stated the x-ray performed at the facility was limited and did not include the Resident's distal femur. Family Member 1 further stated Resident 1 was transferred to the acute care hospital on 8/1/25 due to low hemoglobin. Family Member 1 stated an x-ray was done at the acute care hospital to find out if the resident had any internal bleeding. The x-ray revealed the resident had a fracture of the distal femur and eventually had surgery of the fractured femur which caused the resident to stay in the hospital for 23 days. On 1/30/26 at 1218 hours, an interview and a concurrent record review was conducted with the PT. The PT verified Resident 1 had a fall on 7/25/25, and resident's Rehab-Status Post Fall dated 7/25/25 at 1639 hours, showed the PT had recommended the right hip/femur and knee x-ray due to consistent right hip pain with positive [NAME]. The PT stated recommendations were usually communicated to the nursing department. On 1/30/26 at 1416 hours, an interview and concurrent record review was conducted with RN 2. RN 2 stated the PT would usually have a stop and watch form or verbally inform the nursing staff for any recommendation. RN 1 verified Resident 1's medical record failed to show the physician was informed of the PT's recommendation for x-ray of the right hip/femur to knee. RN 1 verified the order for the bilateral x-ray of hips/femur to knee per DON due to positive [NAME] test with acute pain was ordered on 7/29/25. RN 1 verified Resident 1's medical record failed to show an x-ray result of the bilateral femur and knees as ordered the physician. RN 1 stated the non pharmacological interventions were usually provided to the resident prior administering pain medication for comfort. RN 1 verified Resident 1's MAR showed Resident 1 was provided with the non-pharmacological intervention for pain prior to administering pain medication as above; however, the MAR failed to show if Resident 1 was provided with any pain medication. On 2/5/26 at 0915 hours, an interview was conducted with the DON. The DON stated the expectation regarding the communication of the therapist's recommendation was for the PT to inform the nurse on duty and licensed nurse to report to the physician immediately to prevent delay in treatment. The DON was informed and acknowledged the above findings. b. Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol dated 2001 showed when test results are reported to the facility, a nurse will first review the results. If staff who first received or review laboratory and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate in the procedure. A physician can be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	notified by phone, fax, voicemail, e-mail, pager, or a telephone message to another person acting as the physician's agent. The facility should document information about when, how, and to whom the information was provided and the response. This should be done in the progress notes section of the medical record and not on the laboratory results report. Direct voicemail communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs revies or clarification. A physician should respond within one hour regarding a laboratory test result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate laboratory test notification with a request for response. Review of Resident 1's Order Summary Report showed a physician's order dated 7/30/25, for STAT BMP, CBC, and Mag. Review of Resident 1's Test Results dated 7/30/25, showed the resident's hemoglobin level was 6.3 g/dL . The Reference Range for the hemoglobin level was 11.5-15.0 g/dL. Further review of Resident 1's medical record failed to show if the physician and the family member was notified of the resident's low hemoglobin level of 6.3 on 7/30/25. Review of Resident 1's eInteract SBAR Communication Form and Progress Notes dated 8/1/25 at 0800 hours, showed Resident 1 had an order to be transferred to ER possible blood transfusion. Review of Resident 1's Hospitalist H&P dated 8/1/25, showed the resident presented to ER due to concerns of low hemoglobin. The hemoglobin level result was 6.5 g/dL and the Assessment and Plan section showed gastrointestinal hemorrhage, transfuse one unit PRBC (packed red blood cells) while in ED (Emergency Department). On 1/27/26 at 1619 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated the resident's hemoglobin level was 6.3 on 7/30/25. The facility did not notify her of the laboratory results until 7/31/25 and the resident was not transferred to the acute hospital until 8/1/25, 2 days later. c. Review of the facility's P&P titled Acute Condition Changes - Clinical Protocol dated 2001 showed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. The staff and physician will discuss possible causes of the condition based on factors including resident history, current symptoms, medication regimen, and diagnostic test results. If necessary, the physician will order diagnostic tests and evaluate the patient directly. Review of the facility's P&P titled Laboratory and Diagnostic Test Results - Clinical Protocol dated 2001 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. Review of Resident 1's MDS assessment dated [DATE] showed in section H, for the Bladder and Bowel Function showed the resident had an indwelling catheter. Review of Resident 1's Care Plan Report showed a care plan focused problem initiated on 8/25/25, to address Resident 1's use of the suprapubic catheter secondary to neurogenic bladder and chronic urine retention; at risk for complications related to dislodgement, infection, skin integrity and urinary output. The interventions included to observe for the signs and symptoms of complications related to suprapubic catheter and notify the physician of the abnormal findings; and laboratory as ordered and report the findings to the physician. Review of Resident 1's eInteract SBAR Communication Form and Progress Notes dated 12/13/25, showed family member reported Resident 1 was observed to be lethargic and had sediments on the urine. The Review and Notify section of the SBAR form showed the recommendation of the primary physician was to collect a urine sample. Review of Resident 1's eInteract SBAR Communication Form and Progress Notes dated 12/17/25, showed family member reported Resident 1 was observed to be lethargic, not taking food and drink. The notes further showed the family member wants to transfer the resident to the acute hospital for further evaluation and the physician was notified. Review of Resident 1's laboratory results failed to show a result for the urine sample (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	testing. In addition, there were no physician's order to collect a urine sample for testing. Further review of Resident 1's medical record failed to show if Resident 1's family member refused for the urine test or any indication why the urine sample was not obtained for laboratory testing. Review of Resident 1's SNF/NF to Hospital Transfer Form dated 12/17/25 at 2125 hours, showed Resident 1 was transferred to the acute care hospital. Review of Resident 1's H&P examination from the acute hospital dated 12/18/25 at 0136 hours, showed the physician reviewed the latest laboratory and imaging results. The examination note further showed Resident 1 had acute kidney injury and catheter associated urinary tract infection and will be started on antibiotic treatment. On 1/27/26 at 1619 hours, a telephone interview was conducted with Family Member 1. Family member 1 stated she reported to the nurse when she had noticed the resident's indwelling catheter had sediments and was lethargic; however, the facility was resisting to take the resident to the hospital. Family Member 1 further stated the resident was eventually got transferred to the acute care hospital on [DATE]. On 1/30/26 at 1418 hours, an interview and a concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified Resident 1's eInteract SBAR Communication Form and Progress Notes dated 12/13/25, showed the family member reported Resident 1 was observed to be lethargic and had sediments in the urine. In the Review and Notify section of the form showed the recommendation of the primary physician to collect a urine sample; however, further review of the resident's medical record failed to show the physician's recommendation to obtain urine sample was followed through and no laboratory test was completed for the urine test. RN 2 stated a physician's order should have been written by the nurse as recommended by the physician, a laboratory requisition should have been completed and the family member should have been notified when there was a change in a resident's condition. On 2/3/26 at 0745 hours, an interview was conducted with the DON. The DON stated expectation regarding communicating the change of condition was for the licensed nurses to inform the physician and carry out any laboratory tests recommended to prevent the delay in treatment. On 2/5/26 at 0915 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged findings as above. 3. Review of the facility's P&P titled Medication and Treatment Orders dated 2001 showed orders for medications and treatments will be consistent with principles of safe and effective order writing. Review of the facility's Staffing Assignment dated 1/3/26, showed Stations 3 and 4 had a nurse scheduled to provide the treatments; however, the scheduled nurse did not sign the assignment sheet. In addition, review of the Facility's Staffing Assignment dated 1/4/26, showed no assigned treatment nurse for Stations 3 and 4. a. Review of Resident 1's medical record was initiated on 1/27/26. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of Resident 1's H&P Examination dated 1/21/26, showed resident had no capacity to understand and make decision. Review of Resident 1's MDS assessment dated [DATE] showed Resident 1's BIMS score summary was 3 indicating resident had severe cognitive impairment. Review of Resident 1's order summary dated 2/6/26 showed a physician's order date 12/25/25 for the following:- for the bilateral lower extremity skin discoloration, monitor daily for increase in size, shape, skin breakdown and/ or signs and symptoms of infection until resolved for 30 days;- for the bilateral upper extremity skin discoloration, monitor daily for increase in size, shape, skin breakdown and/ or signs and symptoms of infection until resolved for 30 days;- for the lesion on left thumb, cleanse with normal saline, pat dry apply triple antibiotic ointment and cover with dry dressing every day shift for 30 days; - for MASD (Moisture Associated Skin Damage - is inflammation and erosion of the skin caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound drainage) with excoriation to the left and right buttock, cleanse with normal saline, pat dry, apply skin barrier cream and cover with dry sterile dressing every day shift for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	30 days; - to cleanse suprapubic catheter site with normal saline pat dry, apply T-drain sponge dressing everyday as maintenance;- to monitor suprapubic catheter Fr16/10 ml for placement and functioning every day shift;- to monitor for the proper placement, no kinking or compression that could obstruct urine flow to gravity bag during catheter care every shift- for the suprapubic catheter is in privacy bag and catheter leg strap/leg bag on at all times. The Order Summary Report further showed a physician's order date 12/27/25, for the discoloration to left forearm to cleanse with normal saline, cover with dry dressing daily and as needed every day shift for 21 days. Review of Resident 1's TAR for January 2026 failed to showed the nurse' initials for the following treatments on 1/3 and 1/4/26: - for the bilateral lower extremity skin discoloration, monitor daily for increase in size, shape, skin breakdown and/ or signs and symptoms of infection until resolved for 30 days; - for the bilateral upper extremity skin discoloration, monitor daily for increase in size, shape, skin breakdown and/ or signs and symptoms of infection until resolved for 30 days;- for the discoloration to left forearm to cleanse with normal saline, cover with dry dressing daily and as needed every day shift for 21 days;- for the left thumb, cleanse with normal saline, pat dry apply triple antibiotic ointment and cover with dry dressing every day shift for 30 days; - for MASD with excoriation to the left and right buttock, cleanse with normal saline, pat dry, apply skin barrier cream and cover with dry sterile dressing every day shift for 30 days; - to cleanse suprapubic catheter site with normal saline pat dry, apply T-drain sponge dressing everyday as maintenance.- to monitor suprapubic catheter Fr16/10ml for placement and functioning every day shift In addition, the January 2026 MAR failed to show the nurses' initial on the following treatments:- to monitor for the proper placement, no kinking or compression that could obstruct urine flow to gravity bag during catheter care every shift on 1/1/26, during the evening shift; and 1/3 and 1/4/26, during the day shift; and - for the suprapubic catheter is in privacy bag and catheter leg strap/ leg bag on at all times on 1/1/26, during the evening shift; and 1/3 and 1/4/26, during the day shift. On 1/27/26 at 1619 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated Resident 1's catheter was visibly cloudy and the soiled split gauze was filthy. On 1/30/26 at 1502 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated having no assigned treatment nurse on the weekends could happen and the nurses should do the treatments. LVN 2 verified Resident 1's TAR failed to show the initial of a nurse for the above treatments, indicating the treatment was not completed. b. Review of Resident 3's medical records was initiated on 1/30/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3's BIMS score was 5 indicating resident had severe cognitive impairment. Review of Resident 3's Order Summary Report dated 2/3/26, showed a physician order dated 8/18/25, to cleanse the gastrostomy tube with normal sterile saline, pat dry and cover with T-Drain dressing and secure with tape every day shift daily. Review of Resident 3's TAR for January 2026 failed to show the nurse' initial on 1/4/24 for the treatment order to cleanse the gastrostomy tube with normal sterile saline, pat dry and cover with T-Drain dressing and secure with tape every day shift daily. On 1/30/26 at 1502 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated having no assigned treatment nurse on the weekends could happen and the nurses should do the treatments. LVN 2 verified Resident 3's TAR failed to show the initial of a nurse for the above treatment, indicating the treatment was not completed. c. Review of Resident 4's medical records was initiated on 1/30/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had a BIMS score of 12 indicating the resident had mild cognitive impairment. Review of Resident 4's Order Summary Report dated 2/3/26 showed a physician order dated 12/24/25, to monitor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	the discoloration to both lower extremity daily for increase in size, color, odor and the signs and symptoms of infection and for any changes, to notify the physician; and dated 12/25/25, for the following treatments:- face scattered scabs, to cleanse with normal saline, pat dry, apply triple antibiotic ointment and cover with dry sterile dressing every day shift for 14 days; - left ischial region pressure injury, to cleanse with normal saline, pat dry, apply Santyl (wound treatment), calcium collagen (wound treatment) and cover with foam dressing every day shift for 30 days;- left shin scattered scabs, to cleanse with normal saline, pat dry apply triple antibiotic ointment and cover with dry sterile dressing every day shift for 30 days;- provide low air loss mattress for wound care and skin integrity management, set according to resident's weight, check to ensure proper placement and function; - MASD to sacrum, to cleanse site with normal saline, pat dry apply zinc oxide (wound treatment) and leave open to air monitor every day shift for 14 days; - cleanse the posterior neck redness, with normal saline, pat dry and apply nystatin powder (antifungal treatment) and leave open to air; - cleanse the surgical incision with sutures to right lateral neck extending to clavicle, with normal saline, pat dry, and paint with betadine (antiseptic) and leave open to air every day shift for 30 days;- cleanse the upper back spine surgical incision with sutures with normal saline, pat dry, paint with betadine and cover with dry dressing; and - cleanse the right ischial region pressure injury with normal saline, pat dry, apply Santyl, calcium collagen and cover with foam dressing every day shift for 30 days. Review of Resident 4's TAR for January 2026 failed to show the nurses' initials for the following treatments on 1/4/26:- face scattered scabs, to cleanse with normal saline, pat dry, apply triple antibiotic ointment and cover with dry sterile dressing every day shift for 14 days; - left shin scattered scabs, to cleanse with normal saline, pat dry applytriple antibiotic ointment and cover with dry sterile dressing every day shift for 30 days;- for the low air loss mattress for wound care and skin integrity management set according to resident's weight, to check to ensure proper placement and function; - posterior neck redness, to cleanse with normal saline, pat dry and apply nystatin powder and leave open to air; - surgical incision with sutures to the right lateral neck extending to clavicle, cleanse with normal saline, pat dry, and paint with betadine and leave open to air every day shift for 30 days;- upper back spine surgical incision with sutures, to cl[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure the facility staff provided the necessary emergency care and services to Resident 7. * LVNs 4 and 5 and RN 3 failed to provide continued CPR to Resident 7 when the resident remained unconscious, barely breathing and did not have any blood pressure reading. These failures had the potential to put the resident at risk for care not provided in a safe and competent manner.Findings: Review of the facility's P&P titled Competency of Nursing Staff dated 2001 showed all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. Review of the facility's P&P titled Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support dated 2001 showed personnel are certified in CPR (Cardiopulmonary resuscitation for healthcare providers and BLS (Basic Life Support), including defibrillation for victims of sudden cardiac arrest. If an individual is found unresponsive and not breathing normally, a staff member who is certified in CPR for health care providers or BLS will administer CPR unless: a. it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exist for that individual; or b. there are obvious signs or irreversible death. According to [NAME] A, Singh B, [NAME] PH. Cardiopulmonary Resuscitation. [Updated 2025 Jun 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan from: National Library of Medicine, retrieved [DATE], https://www.ncbi.nlm.nih.gov/books/NBK470402/ chest compressions are the cornerstone of CPR. These compressions generate artificial circulation by increasing intrathoracic pressure, which compresses the heart and propels blood forward. Effective compressions maintain coronary perfusion pressure, which is the difference between aortic diastolic and right atrial diastolic pressure during the relaxation phase of compressions. Coronary perfusion pressure is crucial for myocardial blood flow and is a primary determinant of successful return of spontaneous circulation. Ventilations provide oxygen to the lungs and help maintain blood oxygenation. However, positive-pressure ventilation can reduce coronary perfusion pressure by increasing intrathoracic pressure and impeding venous return to the heart. Therefore, the balance between adequate ventilation and minimizing interruptions to chest compressions is critical. The definitive treatment for ventricular fibrillation and pulseless ventricular tachycardia is electrical defibrillation, most commonly administered using an automated external defibrillator. If defibrillation is not performed promptly, brain death can occur in less than 10 minutes. CPR is a critical intervention to provide artificial circulation and ventilation until defibrillation is possible. When performed correctly, conventional manual CPR can deliver up to 33% of normal cardiac output and oxygenation. The cycle of 30 chest compressions followed by 2 rescue breaths should be continued until an automated external defibrillator becomes available or until additional help arrives. Once an automated external defibrillator is on scene it automatically analyzes the cardiac rhythm and advising whether a shock is necessary. If a shock is advised, chest compressions should be paused, and everyone should stand clear while the automated external defibrillator delivers defibrillation. Immediately after the shock, or if no shock is advised, CPR should be resumed without delay, continuing the CAB (Compressions, Airway, and Breathing) sequence until further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Actual harm Residents Affected - Few	assistance or advanced care arrives. According to American Heart Association's Hard Hats with Heart undated, retrieved [DATE], https://www.heart.org/-/media/Files/Affiliates/WSA/Oregon/CPR-Frequently-Asked-Questions.pdf showed CPR Frequently Asked Questions Toolbox Talks, the section for When do I stop giving Hands-Only CPR? showed to continue pushing hard and fast in the center of the chest until help arrives. If the person speaks, moves, or breathes normally while you're giving chest compressions, Hands-Only CPR can be stopped. Review of Resident 7's medical record was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for full code. Review of Resident 7's POLST dated [DATE], the CPR section indicated to Attempt Resuscitation/CPR and the Medical Interventions section indicated Full Treatment (primary goal of prolonging life by all medically effective means). Review of Resident 7's eInteract SBAR Communication Form and Progress Notes dated [DATE], showed Resident 7 was found on the floor next to the bed, with no response to verbal and tactile stimuli, the assessment revealed asystole and absence of respiration, CPR was initiated and 911 was called. After approximately 20 minutes of CPR, return of spontaneous circulation was achieved and assumed care. The note further showed the fire department arrived, continued CPR and lifesaving measured for another 20 minutes. Further review of Resident 7's medical record failed to show a documentation and/or the vital signs reading when the staff achieved spontaneous circulation. Review of the Resident 7's Electronic Patient Care Report from the Fire Department dated [DATE] at 0236 hours, showed the fire department arrived on scene to find resident on the ground surrounded by care staff pulseless, apneic and without compressions being performed. The manual compressions was initiated. BVM (Bag-Valve-Mask) with high flow oxygen was administered. Defibrillation pads were applied at 0239 hours, resident was PEA (Pulseless Electrical Activity). Review of Resident 7's Emergency Department History and Physical examination dated [DATE], the Disposition section showed unfortunately the patient passed away in the Emergency Department. On [DATE] at 1435 hours, a telephone interview was conducted with the Fire Captain. The Fire Captain stated he arrived at the facility and found resident on the ground surrounded by care staff pulseless and not breathing without compressions being performed. The Fire Captain further stated the staff informed him of the CPR provided to the resident for twenty minutes and had believed heart rate was back and stopped the compression. On [DATE] at 1536 hours, a telephone interview was conducted with LVN 4. LVN 4 stated Resident 7 was unresponsive and had no pulse, and CPR was initiated immediately. LVN 5 provided the compressions while RN 3 provided breathing with the use of Ambu bag. LVN 4 further stated they provided CPR for twenty minutes then the resident's pulse came back, and RN 3 stated to stop the CPR while waiting for the paramedics. On [DATE] at 1611 hours, a telephone interview was conducted with RN 3. RN 3 stated she walked in Resident 7's room with LVN 5 on the scene. RN 3 stated Resident 7 was unresponsive and had no pulse, then LVN 5 and RN 3 initiated CPR immediately. RN 3 stated LVN 5 provided compressions while RN 3 provided breathing with the use of Ambu bag. RN 3 further stated the pulse was achieved prior to the fire department's arrival at the scene. However, RN 3 further stated Resident 7 had no blood pressure and remained unconscious. On [DATE] at 0617 hours, an interview was conducted with LVN 5. LVN 5 stated he found Resident 7 lying on the floor on the left side halfway on prone position. LVN 5 stated Resident 7 had no pulse oximeter reading and RN 3 verified the resident had no pulse and respiration. LVN 5 stated he provided the compressions while RN 3 provided the breathing with the use of Ambu bag. LVN 5 further stated they had performed CPR for 18-20 minutes then obtained a carotid pulse as confirmed by RN 3. LVN 5 stated they stopped the compressions with the presence of carotid pulse. LVN 5 further stated Resident 7 remained unconscious, barely breathing and did not have any blood pressure reading for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER: Huntington Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0726 Level of Harm - Actual harm Residents Affected - Few	approximately 5-7 minutes while waiting for the paramedics to arrive. a. Review of LVN 4's Licensed Nurse Competency dated [DATE], showed LVN 4 met the competency expectations for the emergency equipment. Review of LVN 4's BLS Provider certificate dated [DATE], showed LVN 4 had successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program. b. Review of LVN 5's Licensed Nurse Competency dated [DATE], showed LVN 5 met the competency expectations for emergency equipment. Review of LVN 5's BLS Provider certificate dated [DATE], showed LVN 4 had successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program. c. Review of RN 3's Competency Skills Checklist dated [DATE], showed RN 3 met the competency expectations for emergency equipment, emergency responses, and CPR. Review of RN 3's RQI (Resuscitation Quality Improvement) Healthcare Provider BLS certificate dated [DATE], showed RN 3 had demonstrated competence in High-Quality CPR Skills and had successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program and RQI Program. However, LVNs 4 and 5, and RN 3 failed to provide the continued life-saving measures to Resident 7 when the resident remained unconscious, barely breathing and did not have any blood pressure reading and until the paramedics arrived. On [DATE] at 0850 hours, an interview was conducted with the DON. The DON stated the expectation for the licensed nurses was to continue with the CPR until the fire department arrives and takes over the resuscitation. Cross Reference F684, Example #1.