STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055376	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Drive Health and Rehabilitation Center	400 W. Huntinton Dr. Arcadia, CA 91007

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from physical abuse (intentionally inflicting bodily injury such as slapping, hitting, kicking, and punching). On 4/17/2024, Resident 2 hit Resident 1 on the right cheeks. This deficient practice has the potential for Resident 1 to have psychological distress. In addition, it placed Resident 1 and other residents in the facility for being abused. Findings: A review of Resident 1's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of depressive disorder (involves a depressed mood or loss of pleasure or interest in activities for long periods of time) and epilepsy (a result of abnormal electrical brain activity, also known as seizure, kind of like an electrical storm inside your head). A review of Resident 1's History and Physical (H&P), dated 4/19/2023, indicated resident is able to make decisions. A review of Resident 1's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 5/1/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS also indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or support trunk or limbs, but provides less than half the effort with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Resident required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self and putting on/taking off footwear. A review of Resident 2's Admission Record indicated resident was admitted on [DATE] with the following diagnosis of depressive disorder (involves a depressed mood or loss of pleasure or interest in activities for long periods of time) and senile degeneration of brain (decreased ability to think, concentrate or remember). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's H&P, dated 8/22/2023, indicated resident has poor memory. A review of Resident 2's MDS, dated [DATE], indicated resident was severely impaired with cognitive skills for daily decision making. MDS also indicated resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. A review of Resident 2's Care Plan initiated on 1/1/2023, indicated Resident 2 tossed water on her roommate (not indicated) and demanding her jewelry. A review of Resident 2's progress notes, dated 4/1/2024 at 8:11 PM, indicated Resident 2 struck the charge nurse when Resident 2 was asked not to touch the medication chart. In addition, Resident 2's progress notes, dated 4/6/2024, at 12:27 PM, indicated Resident 2 was trying to exit the back door and when CNA approached Resident 2 to redirect, Resident 2 attempted to strike CNA. A review of Resident 2's Care Plan, dated 4/17/2024, indicated resident had a physical altercation with another resident (Resident 1). During an interview on 5/6/2024 at 11:48 AM, Certified Nursing Assistant 1 (CNA 1) stated while coming out of room [ROOM NUMBER] on 4/17/2024, CNA 1 witnessed Resident 2 hit Resident 1 on the right cheek. During an interview on 5/6/2024 at 2:52 PM, Registered Nurse 1 (RN) 1 stated, Resident 2 intentionally hit Resident 1 on 4/17/2024. RN 1 also stated Resident 2 has moments when she gets agitated (fighting) and being aggressive towards others. During an interview on 5/6/2024 at 3:30 PM, the Director of Nursing (DON) stated Resident 2 had history (on 1/1/2023, 4/1/2024 and on 4/6/2024) of being aggressive towards other residents and staff. The DON stated Resident 2 did not have and should have a staff supervising or monitoring the resident for impulsive behavior or aggressive behavior to prevent further abuse to other residents or being aggressive towards other resident or staff. The DON also stated the incident on 4/17/2024 when Resident 2 hit Resident 1 on the right cheek could have bene prevented if Resident 2 was supervised by a staff. During an interview on 5/7/2024 at 9:09 AM, CNA 2 stated while she was passing out food trays on 4/17/2024, Resident 1 was wheeling himself to the room while passing by Resident 2. Resident 2 stopped Resident 1's wheelchair, saying bad words and hit Resident 1. CNA 2 also stated she was just there and witnessed the incident and no one was supervising or monitoring Resident 2 During an interview on 5/7/2024 at 9:39 AM, CNA 3 stated Resident 2 did not have a facility staff supervising or monitoring the resident to prevent resident from having an aggressive behavior towards another resident. During an interview on 5/7/2024 at 10:57 AM, the DON stated there was no new interventions done for Resident 2 except the order for the medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/7/2024 at 11:12 AM, Resident 1 and 2's room were one room apart. There was no staff observed in the nursing station or in the hallway of Resident 1 and 2's room. During an observation on 5/7/2024 at 12:22 PM, no staff was observed in the nursing station or in the hallway of Resident 1 and 2's room. During an observation on 5/7/2024 at 2:19 PM, no staff was observed in the nursing station or in the hallway of Resident 1 and 2's room. During an interview on 5/7/2024 at 4:34 PM, Administrator (ADM) stated resident did not have facility staff for Resident 2 to provide one to one (1:1, sitter, stays with the resident to provide constant monitoring for resident's safety) supervision to prevent further abuse. A review of the facility's Policy and Procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2022, indicated upon receiving any allegations of abuse, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.

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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** 42223 Based on interview and record review, the facility failed to report immediately not later than two hours of the allegation of physical abuse (intentionally inflicting bodily injury such as slapping, hitting, kicking, and punching) to the State Survey Agency (SSA) for one of four sampled residents (Resident 1) in accordance with the facility's policy and procedure. This deficient practice had the potential to place the residents at risk for elder abuse. Findings: A review of Resident 1's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of depressive disorder (involves a depressed mood or loss of pleasure or interest in activities for long periods of time) and epilepsy (a result of abnormal electrical brain activity, also known as seizure, kind of like an electrical storm inside your head). A review of Resident 1's History and Physical (H&P), dated 4/19/2023, indicated resident is able to make decisions. A review of Resident 1's the Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 5/1/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS also indicated resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or support trunk or limbs, but provides less than half the effort with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Resident required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self and putting on/taking off footwear. During an interview on 5/6/2024 at 11:48 AM, Certified Nursing Assistant 1 (CNA 1) stated while coming out of room [ROOM NUMBER] on 4/17/2024 around lunch time, CNA 1 witnessed Resident 2 hit Resident 1 on his right cheek. During an interview on 5/6/2024 at 1 PM, the Director of Nursing (DON) stated she tried to send the report on 4/17/2024 to the SSA but it was busy, so it did not go through. The DON also stated she should have double checked to make sure the facsimile (fax, a telephone transmission, via a phone line, of a scanned copy of images and text printed on paper, transmitted between two people) report went through to make sure SSA was informed within the two (2)- hour time frame from when the incident between Resident 1 and 2 happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2024 at 3:10 PM, Administrator (ADM) stated report to the state agency should be within 2 hours from the alleged abuse or witnessed abused. The altercation between Resident 1 and 2 was not reported to SSA on 4/17/2024 within 2- hour from the incident. ADM stated, if the fax is busy, he would try it again until he got a confirmation stating the fax has been sent successfully. A review of the facility's Policy and Procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2022, indicated the administrator or the individual making the allegation immediately (within 2 hours of an allegation involving abuse) reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility.