

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Huntington Drive Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on interview and record review, the facility failed to immediately notify the attending physician regarding the left sided chest pain for one (1) of four (4) sampled resident (Resident 1) in accordance with the facility's policy.</p> <p>This deficient practice had the potential to result in delayed provision of necessary care and services for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis that included angina pectoris (chest pain caused by reduced blood flow to the heart muscles).</p> <p>A review of Resident 1's History and Physical (H&P), dated 6/7/24, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool), MDS dated [DATE], indicated Resident 1 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) lower body dressing, putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and shower. The MDS further indicated Resident 1 required partial assistance (helper does less than half the effort) with oral and personal hygiene, and upper body dressing.</p> <p>A review of Resident 1's change in condition (COC, change in a resident's physical or mental health) evaluation dated 6/21/24 at 11:57 AM and electronically signed by Licensed Vocational Nurse 1 (LVN 1) indicated Resident 1's chest pain was reported to the primary care physician at 11:50 AM.</p> <p>A review of Resident 1's Physician's Order, dated 6/21/24 at 12:07 PM, indicated a stat (urgent) electrocardiogram (EKG, measures the hearts electrical activity) order for chest pain.</p> <p>A review of the Nurses Progress Notes, electronically signed by LVN 1 and dated 6/21/24 at 12:48 PM, indicated Resident 1 stated he felt chest pressure (chest pain/ discomfort) at 8:48 AM while the resident was in his room.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 12:30 PM, LVN 1 stated Resident 1 had chest pain (unable to recall if left or right side) on 6/21/24 at 8:45 AM. LVN 1 also stated she was aware her priority should have been to follow up on the Resident 1's chest pain and it was important to immediately call the doctor because Resident 1 could have a heart attack. LVN 1 further stated she did not notify the Director of Nursing (DON) and asked for help.</p> <p>During an interview on 7/10/24 at 1:11 PM, Certified Nursing Assistant 2 (CNA 2) stated Resident 1 informed her of the chest pain around 10 AM to 10:30 AM right after the resident's physical therapy session and notified LVN 1. Resident 1's chest pain should have been reported to his attending physician right away to find out if the resident had a heart attack or not.</p> <p>During an interview on 7/10/24 at 1:46 PM, the Case Manager (CM) stated Resident 1 flagged her down on 6/21/24 at 12 Noon and stated he had a non-radiating left sided chest pain with a scale of eight (8) out of ten (10) (0 means no pain, and 10 means the worst pain you have ever known). The CM also stated Resident 1 had expressed and communicated his chest pain to the charge nurse since that morning of 6/21/24.</p> <p>During an interview on 7/10/24 at 3:30 PM, the DON stated the licensed nurse assigned to Resident 1 should have called the attending physician to notify the physician regarding the resident's chest pain right away. The DON also stated the licensed nurse should have assessed the resident and called the attending physician after she took the vital signs (measurement of the heart rate, breathing and blood pressure) to get an order so there would be no delay in care. The DON further stated licensed nurse was to notify the attending physician of Resident 1's change in condition so the resident can get immediate and proper care to treat and prevent worsening of the resident's condition.</p> <p>During an interview on 7/10/24 at 3:57 PM, LVN 2 stated for the residents experiencing chest pains, the staff should have called or assigned someone to call the doctor right away. LVN 2 also stated any significant change in condition, the attending physician should be notified immediately especially chest pain because the resident could have a heart attack and needed to be attended right away and may need to be transferred to the hospital.</p> <p>During an interview on 7/10/24 at 4:25 PM, LVN 3 stated chest pain was considered a significant change in condition.</p> <p>During an interview on 7/10/24 at 4:40 PM, LVN 2 stated chest pain is considered a significant change in condition because a lot of things could have happened to Resident 1 and the resident may need to be transferred to the hospital.</p> <p>During a concurrent interview and record review on 7/10/24 at 4:45 PM, the DON stated chest pain was a significant change in condition.</p> <p>A review of the facility's policy titled, Change in a Resident's Condition or Status, revised February 2021, indicated that the facility promptly notifies the residents attending physician of the changes in the resident's medical condition and/or status.</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</p> <p>Based on interview and record review, the facility failed to ensure the STAT (urgent) electrocardiogram (EKG, measures the hearts electrical activity) test was promptly acted on for one (1) of four (4) sampled resident (Resident 1) as indicated with the physician's order and EKG results was not relayed to the physician as soon as the result was available in accordance with the facility's policy.</p> <p>This deficient practice resulted in delay in conducting the EKG test which could potentially lead to a delay in diagnosis and treatment for Resident 1's abnormal EKG result of Sinus Rhythm with first degree atrioventricular block (a heart rhythm disorder that causes the heart to beat more slowly than it should).</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis that included angina pectoris (chest pain caused by reduced blood flow to the heart muscles).</p> <p>A review of Resident 1's History and Physical (H&P), dated 6/7/24, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 6/13/24, indicated Resident 1 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) lower body dressing, putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and shower. The MDS further indicated Resident 1 required partial assistance (helper does less than half the effort) with oral and personal hygiene, and upper body dressing.</p> <p>A review of Resident 1's Physician's Order, dated 6/21/24 at 12:07 PM, indicated a stat EKG order for chest pain.</p> <p>A review of Resident 1's medical records indicated the EKG was done on 6/21/24 at 9:35 PM and has a result of Sinus Rhythm with first degree atrioventricular block.</p> <p>During an interview on 7/10/24 at 1:11 PM, Certified Nursing Assistant 2 (CNA 2) stated she was assigned to Resident 1 on 6/21/24, 7 AM to 3 PM shift and did not see an EKG technician arrived by the time she left the facility that day.</p> <p>During a concurrent interview and record review on 7/10/24 at 1:46 PM, the Case Manager (CM) stated Resident 1's EKG was done at 9:35 PM on 6/21/24.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 3:30 PM, the Director of Nursing (DON) stated, the EKG order should have been followed up and done as soon as it was ordered to make sure there was no delay in the interventions and care for the resident. The DON also stated the charge nurse or Registered Nurse (RN) supervisor should have notified the attending physician of the result of Resident 1's EKG when it was done on 6/21/24 at 9:35 PM to find out if there is any new orders for Resident 1.</p> <p>During an interview on 7/10/24 at 3:57 PM, LVN 2 stated stat orders should be done within four (4) hours. LVN 2 also stated the RN supervisor or the staff in charge of Resident 1 should have followed up when the EKG technician failed to come within 4 hours since the test should have been done right away to find out what was going on with Resident 1.</p> <p>During an interview on 7/10/24 at 4:25 PM, LVN 3 stated the attending physician should be notified of the EKG result and documented in the nurses' progress notes.</p> <p>During a concurrent interview and record review of Resident 1's medical records dated from 6/21/24 to 7/10/2024, on 7/10/24 at 4:45 PM, the DON stated there was no documentation by the nurses regarding notification of the attending physician regarding the EKG result of Resident 1 done on 6/21/24. The DON also stated the attending physician should be notified of the EKG result so they could provide a definitive diagnosis and prompt treatment for Resident 1.</p> <p>A review of the facility's policy titled, Test Results, revised April 2007, indicated that the residents attending physician will be notified of the results of diagnostic tests. The policy also indicated that should the test results be provided to the facility, the attending physician shall be promptly notified of the results.</p> <p>A review of the facility's policy titled, Request for Diagnostic Services, revised April 2007, indicated that all orders for diagnostic services will be promptly carried out as instructed by the physician's order. The policy also indicated that emergency requests must be labeled stat to assure that prompt action is taken.</p>