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	07/12/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review the facility failed to implement their policy for abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and includes verbal abuse [a range of words of behaviors used to manipulate, intimidate, and maintain power and control over someone]) for one (1) of four (4) sampled residents (Resident 1) by failure to report to the state agency (CDPH; California Department of Public Health), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement (Police Department) and failed to investigate an allegation of verbal abuse by two Certified Nursing Assistants (CNAs). This failure resulted in the facility not reporting or investigating the alleged verbal abuse and putting Resident 1 at risk for another episode of verbal abuse. Findings: During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease) and type two (2) diabetes (a disease that occurs when your blood sugar is too high). During a review of Resident 1's History and Physical Examination (H&P), dated 6/19/2024, H&P indicated the resident has the capacity to understand and make decisions and can make needs known but can not make medical decisions due to debilitated state (physically weak) and pain management (the process of providing medical care that alleviates or reduces pain). During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 6/24/2024, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills of daily decision making, but needed partial/moderate assistance (helper does less than half the effort) with chair-to-bed transfers, needed substantial/maximal assistance (helper does more than half the effort) with toilet transfers, going from lying to sitting on the side of the bed and with dressing (how resident puts on, fastens and takes off all items of clothing) and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. (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: 055376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: Huntington Drive Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 W. Huntinton Dr. Arcadia, CA 91007	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024 at 9:18 AM with Family Representative (FR), FR stated Resident 1 had complained to the facility Case Manager (CM) on 7/3/2024 about an allegation of verbal abuse that she experienced on the night of 7/2/2024 when two CNAs (unable to identify) had used foul language (expressions such as swear words that are regarded as coarse, obscene [rude or shocking] or otherwise unacceptable in polite or formal speech) towards Resident 1 while assisting the resident. During an interview on 7/12/2024 at 10:15 AM with CM, CM stated they met with Resident 1 and FR on 7/3/2024 where Resident 1 told them that on 7/2/2024 in the evening shift, the resident was being assisted by two CNAs and one of the CNAs was using foul language with the resident and CNA told the resident What do you want, are you f***ing done? and What do you need now?. Resident 1 told CM that the CNAs were working in pairs and that the other CNA (unable to identify) was behaving the same way. CM stated that Resident 1 also gave a description of the CNAs and that they had communicated about the incident about the 2 CNAs to the facility Administrator (ADM), Director of Nursing (DON) and Social Services Director (SSD) on 7/3/2024 at 12:40 PM. CM further stated they only reported the incident to the facility's leadership team and did not report it to CDPH, the police of the Ombudsman and was not sure what happened of if it was investigated since they had notified the ADM who is the facility's abuse coordinator. During an interview on 7/12/2024 at 10:24 AM with ADM, ADM stated he was not made aware of the incident of alleged verbal abuse that Resident 1 had complained about on the evening of 7/2/2024 and stated that he is not aware of this particular incident being reported or investigated because he would have been the one to have reported it to the proper entities (CDPH, ombudsman and local police department). ADM also stated he would most definitely consider someone using foul language with a resident as an allegation of verbal abuse and should have been investigated right away as soon as it was witnessed, or allegation was made. During an interview on 7/12/2024 at 12:48 PM with Registered Nurse 1 (RN 1), RN 1 stated they would consider someone speaking to another resident using foul language as verbal abuse and that if they were made aware of any allegations of abuse, they would report it within 24 hours to ADM, DON, CDPH, the Ombudsman and the police. During an interview on 7/12/2024 at 1:00 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated they would consider someone using foul language as verbal abuse and that if they were ever made aware of an allegation of abuse, they would report it right away to the ADM who is the facility's abuse coordinator. LVN 1 also stated the timeline to report is within two hours and that all abuse allegations should also be reported to the Ombudsman, CDPH & the police. During an interview on 7/12/2024 at 3:47 PM with the Director of Nursing (DON), the DON stated they were just made aware now of the incident of alleged verbal abuse with Resident 1 and stated that after hearing about it, they would report the incident to the ADM, suspend the employees pending investigation, call the police, the Ombudsman, CDPH and facility medical director as well as assess the resident for psychological (mental or emotional) and psychosocial (pertaining to the influence of social factors on an individual's mind or behavior) distressed from the alleged abuse. The DON also stated she would consider the situation that Resident 1 complained about against the two CNAs as verbal abuse and that all facility staff are mandated (to administer or assign something) reporters and that are responsible for reporting any allegation of possible abuse. The DON further stated since it was just now brought to their attention, they are now going to investigate it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Identifying Types of Abuse revised September 2022, the P&P indicated verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability and exampled of mental and verbal abuse include, but are not limited to: Harassing a resident; Mocking, insulting, ridiculing; Yelling or hovering over a resident, with the intent to intimidate; During a review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022, the P&P indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigation are documented and reported. The P&P also indicated: > Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspected, the suspicion must be reported immediately to the administrator and to the other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility's medical director. 3. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or > Investigating Allegations - All allegations are thoroughly investigated. The administrator initiates investigations.