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	07/01/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 and record review, the facility failed to document assessment, notify attending physician (MD), do a Change of Condition (CoC) and monitor the CoC for one of two sampled residents (Resident 1) in accordance with the facility's Change in a Resident's Condition policy after Resident 1 reported that the resident hit her head while in the bathroom to the Director of Staff Development (DSD) on 6/30/2025. This deficient practice had the potential to cause Resident 1 to have delayed treatment, untreated injury and worsening injury. Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (loss of blood flow to a part of the brain) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/7/2025, the MDS indicated the resident was assessed to have intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent (helper does all effort) when putting on/taking off footwear. The MDS also indicated Resident 1 was assessed to require substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering, upper body dressing, lower body dressing and personal hygiene. The MDS also indicated Resident 1 required set up assistance (helper sets up or cleans up) for eating and oral hygiene. During a record review of Resident 1's Progress Notes dated 6/30/2025, the Progress Notes did not have documented evidence of Resident 1 hitting her head while in the bathroom and that Resident 1 was assessed, monitored and treated after hitting her head on 6/30/2025. The Progress Notes did not indicate Resident 1. During an interview on 7/1/2025 at 3:44 PM with Resident 1, Resident 1 stated that on 6/30/2025 she told the DSD that Resident 1hit her head on the grab bar while in the restroom. During an interview on 7/2/2025 at 1:46 PM with the DSD, the DSD stated that on 6/30/2025 Resident 1 had reported to DSD that the resident hit her head while the resident was in the restroom. DSD stated she did not report it to Resident 1's MD, documented the assessment of Resident 1 head and did not do a CoC. The DSD stated a resident hitting their head is considered a CoC and she should have reported it to Resident 1's MD and done a CoC and monitored resident's condition. During a concurrent interview and record review on 7/2/2025 at 2:03 PM with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated 2/2021 was reviewed. The P&P indicated:1. The facility promptly notifies the resident, his/her MD, and the resident representative of changes in the resident's medical/mental condition and/or status.2. The nurse will notify the resident's MD on call when there has been an accident or incident involving the resident.3. Prior to notifying the MD, the nurse will make detailed observations and gather relevant information for the provider.4. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The DON stated that the P&P indicated that the resident's MD must be notified of a CoC and the nurse's assessment must be documented in the resident's medical record. The DON stated that if a resident reports that they hit their head, the MD must be notified even if it was unwitnessed. The DON stated the nurse must then assess the resident, do a CoC, document the assessment, and monitor the resident for 72 hours. The DON stated that if a resident is not monitored after an accident, and the MD was not made aware to obtain MD orders, the resident may have delayed treatment, untreated injuries and the resident's injuries could get worse.