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	08/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity and respect for two (2) of 3 residents (Residents 2 and 3) based on the facility's policy by failing to: 1. Ensure Resident 2's privacy curtain was closed and the resident's (a movable fabric barrier designed to provide a private enclosure and block views, commonly used in healthcare settings like hospitals and nursing homes to create patient seclusion) inner thighs were covered and were not exposed while the resident was lying on his bed on 8/11/2025.2. Accommodate Resident 3's request to be gentle when providing perineal care (cleaning the private areas of a resident) from Certified Nursing Assistant 1 (CNA 1). This deficient practice had the potential to affect Resident 2 and 3's sense of self-worth and self-esteem which could result in problems with emotional and mental well-being.Findings:1. During a review of Resident 2's admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2's diagnoses included chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), and muscle weakness. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 8/4/2025, the MDS indicated Resident 2 has moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower/ bathe self, upper body dressing, personal hygiene, chair/bed- to chair transfer, toilet transfer, and tub/shower transfer. During an observation on 08/11/2025 at 9:29AM outside Resident 2's room, Resident 2 was sitting on his bed, privacy curtain not closed, the resident was wearing a hospital gown with the resident's legs exposed and no blanket. Resident 2's both legs were far apart, and the resident's inner thighs were visible from the hallway. During a concurrent observation and interview on 8/11/2025 at 10:39AM with CNA 2 outside of Resident 2's room, Resident 2's left inner thigh can be seen in the hallway. CNA 2 stated, It is not okay that we can see Resident 2's inner thighs in the hallway. We need to cover it, because it is Resident 2's privacy and dignity. During a concurrent observation and interview on 8/11/2025 at 10:41AM with the Director of Nursing (DON) outside of Resident 2's room, Resident 2's inner thigh was exposed and can be seen from the hallway. The DON stated, We should pull the privacy curtains to provide privacy to Resident 2. Resident 2's inner thigh should not be seen in the hallway. We need to cover him, because of dignity. During a concurrent observation and interview on 8/11/2025 at 10:42 AM with Resident 2, Resident 2 pulled down his gown and made sure his thighs were covered. Resident 2 stated, Well it is not okay that other residents can see my inner thighs. During a record review of facility's P&P titled, Dignity revised 2/2021, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P also indicated residents are to be always treated with dignity and respect and staff to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 2. During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 diagnoses included hemiplegia (paralysis of one side of the body), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and anxiety disorder (a disorder characterized by nervousness characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior [repetitive, persistent, and often uncontrollable actions that a person feels driven to perform] or panic attacks). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 has moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, and chair/bed-to chair transfer. During a review of Resident 3's Care Plan (CP) for at risk for further decline in function, joint mobility, contracture formation, falls, skin breakdown and increased dependence in Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), dated 1/14/2022, the CP indicated in the interventions/approaches, needs extensive assistance with bed mobility, w/ 2 persons physical assist, locomotion off unit, dressing, toileting, personal hygiene. During an