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	08/29/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 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 interviews and record review, the facility failed to document an episode of dizziness for one (1) of two (2) sampled residents (Residents 1) who experienced change with condition in the resident's nurses' progress notes (nurses detailed, day-to-day journal about patient care) in accordance with the facility's policy and procedure (P&P) titled, Charting and Documentation. This deficient practice resulted in the medical records inaccurate representation of care provided and placed Resident 1 at risk of complications.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a slight loss of strength in a leg, arm, or face) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant (weaker) side and left hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 7/7/2025, the MDS indicated Resident 1 had an intact 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) with putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene, shower and upper and lower body dressing. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with eating and oral hygiene. During a concurrent observation and interview on 8/29/2025 at 10 AM, Resident 1 was lying in bed with a small electric fan on the floor near the foot of the resident's bed. Resident 1 stated she gets dizzy when there is no air circulating in the room. Resident 1 also stated she did not remember the last time she felt dizzy, but it was a few days ago and told Registered Nurse 1 (RN 1) that Resident 1 was feeling dizzy and had an episode of vomiting that same day. During a concurrent interview and record review on 8/29/2025 at 12:14 PM with the Licensed Vocational Nurse 1 (LVN 1), Resident 1's nurses progress note dated 8/17/2025 was reviewed. LVN 1 also stated there was no documentation in Resident 1's nurses progress notes about dizziness or vomiting on 8/17/2025. LVN 1 also stated dizziness, or vomiting should be documented in the nurses' progress notes so that they could find out why and what was causing those symptoms. During an interview on 8/29/2025 at 1:40 PM, LVN 2 stated, when the resident experienced dizziness or vomiting, it needs to be charted in the nurses' progress notes so the licensed staff can follow up and monitor the resident if she has another episode. During an interview on 8/29/2025 at 2 PM, RN 1 stated she should have documented Resident 1's episode of dizziness last 8/17/2025 in the nurses' progress notes so the other licensed staff would be able to follow up if there is another episode of dizziness, provide appropriate intervention and to notify the Resident 1's physician if the symptom persists. During a concurrent interview and record review on 8/29/2025 at 2:56 PM with the Director of Nursing (DON), Resident 1's Care Plan for At risk for fall dated 7/1/2025 was reviewed. The care plan indicated intervention to document any chief complaint of dizziness. The DON stated according to Resident 1's care plan, the licensed staff should document episodes and frequency of Resident 1's dizziness in the nurses' progress notes to see if more interventions are needed for Resident 1. During a review of the facility's undated policy and procedure (P&P) titled, Charting and Documentation, revise July 2017, the P&P indicated, all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between interdisciplinary teams regarding the residents' condition and response to care. The policy also indicated that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.