

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 11/18/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff followed the facility's policy and procedures (P&P) titled Indwelling (Foley) Catheter Insertion, Female Resident for one (1) of three (3) sampled residents (Resident 1) by not documenting the indication for Foley catheter (tube that drains urine from the bladder (organ that collects and stores urine) into a drainage bag) use as required by the P&P. This failure had the potential to cause harm by increasing the risk of infection, improper catheter use, and inadequate monitoring of the resident condition. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnosis which included hypertension (high blood pressure), osteoarthritis (the cartilage within a joint begins to break down and the underlying bone begins to change causing reduced function and disability), lack of coordination. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/17/2025, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making was modified independence (some difficulty in new situations only). The MDS also indicated Resident 1 was supervision or touching assistance (helper provides verbal cues and/or touching/steadying) on toileting hygiene, upper body dressing, personal hygiene. The MDS also under urinary continence (ability to voluntarily control the discharge of urine) indicated occasionally incontinent (inability to control). During a review of Resident 1's Order Summary Report dated 10/3/2025, indicated may do in and out catheter, if residual urine is greater (>) than 300 milliliters (unit of fluid volume), keep foley in. The order summary also indicated Foley catheter French 16 (size) with 10 cubic centimeters (the volume of sterile water, expressed in cubic centimeters (cc) used to inflate the retention balloon of a indwelling catheter to hold it in place inside the bladder) to bed side drainage (BSD, bag attached to the indwelling urinary catheter to collect the urine). During a review of Resident 1's Care Plan Report date initiated 10/13/2025 titled Indwelling Catheter (tube that drains urine from the bladder into a drainage bag) indicated the resident was at risk for infection due to an indwelling catheter. The care plan also indicated to monitor and document intake and output as per facility policy. During a concurrent interview and record review on 11/17/2025 at 8:00 AM with the License Vocational Nurse (LVN 1) of Resident 1's Order Summary Report, LVN 1 stated the order for the Foley catheter did not include an indication for its use. During a concurrent interview and record review on 11/17/2025 at 8:05 PM with LVN 1 of Resident 1's Progress Notes (documented records of a resident's condition, care, and progress in their medical chart), LVN 1 stated there was no documentation in the progress notes regarding the urine output, color, clarity, amount of the urine obtained during the procedure. LVN 1 also stated no documentation found how the resident tolerated the procedure. During a concurrent interview and record review on 11/17/2025 at 8:10 AM with LVN 1 of Resident 1's Care Plan Report date initiated 10/13/2025 titled Indwelling Catheter, LVN 1 stated the care plan indicated monitoring intake and output as per policy. LVN 1 stated there was no care plan developed for the foley catheter on 10/3/2025. The facility should have developed and implement the care plan when the foley was inserted on 10/3/2025. During an interview with LVN 1 on 11/17/2025 at 8:15 AM, LVN 1 stated Resident 1 requested a foley catheter. The nurse called and informed the primary medical doctor (PMD) regarding Resident 1's request, and the PMD gave an order to insert foley catheter. LVN 1 stated the order indicated that if the output was greater than 300 ml the Foley would remain in place. During an interview on 11/17/2025 at 10:16 AM with LVN 2, LVN2 stated Resident 1's order for Foley catheter did not include an indication. LVN 2 also stated we cannot just insert Foley without indication due to high risk for infection. During a concurrent interview and record review on 11/17/2025 at 10:29AM with the Director of Nursing (DON), of the facility's P&P titled Indwelling (Foley) Catheter insertion, Female Resident the DON stated the P&P indicated the following under Documentation:The date and time the procedure was performed.The indication(s) for catheter use.The name title and title of the individual(s) who perform the procedure.All assessment data (example (e.g., urine character, color, clarity, etcetera (etc., used at the end of a list to indicate that further similar items are included) obtained during the procedure.The size of the catheter inserted, and the amount of sterile water used to inflate the balloon.How the resident tolerated the procedure. The DON stated the P&P was not followed for Resident 1's Foley catheter insertion. There was no indication documented for the catheter, no documentation completed on the time of insertion, and no monitoring of input and output for Resident 1's in the progress notes. The DON stated the Foley catheter order did not include the indication and the foley</p>		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the physical environment in a safe and sanitary condition by failing to ensure there was no water leak in the facility ceiling from 11/15/2025 to 11/18/2025 by failing to:Ensure there was no water leak in the ceiling at the hallway in front of the oxygen room from 11/15/2025 to 11/16/2025.Ensure there was no water leak in the ceiling of Resident 4's room.This deficient practice had the potential to cause harm by creating slip hazards, increase the risk for mold growth and compromise the safety and comfort of residents, staff and visitors. Findings: 1. During an observation of the facility's ceiling in the hallway in front of oxygen room on 11/17/2025 at 6:33 AM, the ceiling was observed with a large hole with visible water damage. The water leaked from the damaged area, into a large gray bin that was placed underneath to catch the water. Towels were placed on the floor around the large gray bin.During a concurrent interview on 11/17/2025 at 9:56 AM with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated the water leakage started when it started to rain on 11/15/2025 to 11/16/2025. The ADM also stated the maintenance assistant (MTA) was sick, and the maintenance supervisor was on leave. But they are fixing the roof now 11/17/2025. During an interview on 11/17/2025 at 11:32 AM with MTA, MTA stated he was fixing the roof today, as he was informed last Saturday 11/15/2025. During a concurrent observation, interview and record review on 11/17/2025 at 12:30 PM, the License Vocational Nurse (LVN 2), LVN 2 stated the ceiling in front of the oxygen room had peeling paint and a hole in the ceiling with visible water damage. LVN 2 also stated a large gray bin was placed underneath to catch the rainwater. On the floor there were towels around the large gray bin to absorb any rainwater that did not fall into the large gray bin. LVN 2 also stated the facility should not have leaks and it was dangerous. LVN 2 stated the building should be in good repair and free of hazards for the safety of staff and residents in accordance with the facility's policy and procedures (P&P) titled Maintenance Services. During an interview on 11/17/2025 at 1:00 PM with MTA, MTA stated there was a quarter size hole in the roof that caused the leakage in the hallway in front of the oxygen room. During a review of the facility's P&P titled Maintenance Service revised date 12/2009, indicated maintenance service shall be provided to all areas of the building, ground and equipment. The P&P also indicated the maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe operational manner at all times. 2. During a review of Resident 4's admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE] and re-admit 10/15/2025. Resident 4's diagnoses included congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide) with hypoxia (low levels of oxygen in the body tissues) and generalized muscle weakness. During a review of Resident 4's Minimum Data Set (MDS, resident assessment tool), dated 10/1/2025, the MDS indicated Resident 4 modified independence (some difficulty in new situations only) in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 4 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer, and tub/shower transfer. During a concurrent observation in Resident 4's room and interview on 11/18/2025 at 9:40 AM, Resident 4's ceiling was observed with grayish colored discoloration. Resident 4 stated his ceiling had water leak last night (11/17/2025 night) and pointed at the ceiling discoloration as watermarks because water was dropping from the ceiling last night. Resident 4 stated some of his personal items on his bedside table were soaked with water from the rain and the water was coming in from the outside through the screen door, and water was seeping through the walls, then Resident 4 pointed the watermarks on the wall and the ceiling. During a concurrent observation and interview on 11/18/2025 at 9:42 AM, with Registered Nurse Supervisor 1 (RNS 1) inside Resident 4's room, RNS 1 looked at Resident 4's ceiling and saw the grayish colored discolorations on the ceiling and wall. RNS 1 stated there was a leak in a resident's room, and it is a safety issue. RNS 1 stated Resident 4 can also get wet from the water leaking from the ceiling. During a concurrent observation and interview on 11/18/2025 at 9:47 AM with Maintenance Assistant (MTA) inside Resident 4's room. MTA was looking at the ceiling with watermarks and stated those are water marks from the leak on the</p>		