

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  11/19/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide respiratory care services for two (2) of two sampled residents (Resident 1 and 2) in accordance with the facility's policy and procedure by failing to ensure: 1. Resident 1 received oxygen on 11/18/2025 as ordered via nasal cannula (NC, device used to deliver supplemental oxygen placed directly on a resident's nostril). 2. Resident 2's oxygen saturation (level of oxygen found in a person's blood, normal reference= 95-100 %) which was below 92% on 10/4/2025, 10/11/2025 and 10/15/2025 was reported to the physician per physician's order. These deficient practices have the potential to place Resident 1 and 2 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which could lead to irreversible health damages and/or death. Findings: 1. During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included acute and chronic respiratory failure with hypercapnia (occurs when a resident with a pre-existing, long-term condition that causes high carbon dioxide levels experiences a sudden, acute worsening of the condition), acute respiratory failure (occurs when the resident do not have enough oxygen in the blood) with hypoxia, asthma (a condition in which the resident's airways narrow and swell and may produce extra mucus), and dementia (a progressive state of decline in mental abilities) During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 9/11/2025, the MDS indicated Resident 1 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 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, roll left and right, sit to lying, lying to sitting on the side of the bed and chair/ bed-to-chair transfer. During a record review of Resident 1's Order Summary, dated 3/10/2025, the order summary indicated: Oxygen at three (3) liters per minute (lpm, unit of measurement) via nasal cannula continuously. Diagnosis: Respiratory Failure every shift. Monitor Oxygen Saturation every shift. Notify MD (physician) if Oxygen Saturation was less than 90%. During a record review of Resident 1's undated care plan, the care plan indicated Resident 1 has Oxygen Therapy related to Respiratory illness, acute and chronic respiratory failure with hypercapnia (occurs when a patient with a pre-existing, long-term condition that causes high carbon dioxide levels experiences a sudden, acute worsening of the condition). The care plan indicated Resident 1 has oxygen via nasal prongs/mask at 3lpm continuously. During a concurrent observation and interview on 11/18/2025 at 9:37AM inside Resident 1's room, Resident 1 was sleeping, and observed not wearing a nasal cannula. The oxygen tubing with the cannula was placed on top of Resident 1's chest. The oxygen concentrator was running and was set up at 2.5 lpm. Resident 1 observed to have woken up and stated her oxygen cannula came off this morning and added that she was feeling weak and tired. During a concurrent observation and interview on 11/18/2025 at 9:28 AM with the Director of Nursing (DON) inside Resident 1's room, the DON saw Resident 1's oxygen tubing with the cannula on top of resident's chest. The DON asked Resident 1 if why was her nasal cannula on top of her chest. Resident 1 stated it came off this morning. During an observation and interview on 11/18/2025 at 11:30 AM, inside Resident 1's room, Resident 1 was observed not wearing her oxygen cannula, which was resting on the resident's chest. The oxygen concentrator was observed to be on and set at 2.5 lpm. During a concurrent observation and interview on 11/18/2025 at 11:31 AM inside Resident 1's room, the DON observed and confirmed Resident 1's oxygen tubing with the cannula was resting on top of Resident 1's chest. The DON stated Resident 1's oxygen concentrator was set up at 2.5 lpm which was the incorrect setting. The DON stated Resident 1 can experience low oxygen saturation. The DON added Resident 1 should be administered oxygen continuously per order. During a concurrent observation and interview on 11/18/2025 at 11:44 AM with Licensed Vocational Nurse 1 (LVN 1) inside Resident 1's room, LVN 1 stated Resident 1's oxygen concentrator was set up at 2.5 lpm which was the incorrect setting. LVN1 stated, The oxygen concentrator should be at 3 lpm. The resident will not get enough oxygen, and her oxygen saturation can go lower than 90%. During a record review of facility's Policy and Procedure (P&amp;P) titled, Oxygen Administration, revised 10/2010, the P&amp;P indicated, 1. Review the physician's orders or facility protocol for oxygen administration. 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 3</p>		