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	01/07/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat two (2) of 2 sampled residents (Resident 1 and 2) with respect and dignity when:1) Resident 1 was left sitting on the wheelchair for 2 and half hours while waiting for the resident's clothes and personal belongings left on the resident's bed to be put away on 12/11/2025 when resident was transferred to a new room. Resident 1 was also not provided with a functional television (TV) remote control since 12/11/2025.2) Resident 2 was provided with a TV without the channel of resident's choice since 12/15/2025.These deficient practices had the potential to negatively affect Residents 1 and 2's psychosocial well-being and quality of life.Findings:1. 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 bilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip and presence of right artificial knee joint. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 9/8/2025, the MDS indicated Resident 1's activity preference to keep up with the news was somewhat important. During a review of Resident 1's MDS dated , 9/11/2025, the MDS indicated Resident 1 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with shower and required partial/moderate assistance (helper does less than half the effort) with lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 1 required supervision (helper provides cues) with oral and toileting hygiene and upper body dressing and required setup assistance (helper sets up; resident completes activity) with eating. During a concurrent observation in Resident 1's room and interview on 1/6/2025 at 10:38 AM, Resident 1 was sitting at the side of the bed. Resident 1 stated he does not read so his preference was to watch TV, but the facility never brought in a functional TV remote control. During an interview on 1/6/2025 at 11:12 AM, Certified Nursing Assistant 1 (CNA 1) stated everything that was provided to the residents in the facility should be in good working order. CNA 1 also stated it is one of their rights as a resident in the facility. During interview with Resident 1 on 1/6/2025 at 11:30 AM, Resident 1 stated he was moved to his current room (Room B) on 12/11/2025. Resident 1 stated the facility staff threw all his clothes and personal belongings from his previous room (Room A) onto his bed in Room B. Resident 1 stated he wanted to lie down in bed but had to sit on the wheelchair for approximately 2 1/2 hours because his clothes and personal belongings were on the bed. Resident 1 added that his caregiver eventually put his clothes and personal belongings in the drawer when he arrived at the facility to visit him. During an interview on 1/6/2026, at 11:45 AM, Resident 1's caregiver (CG) stated that Resident 1 was sitting in his wheelchair when he arrived at the facility on 12/11/2025 (exact time not recalled), and that the resident's clothes and personal belongings were on top of the bed. CG stated that Resident 1 could (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not lie down after being transferred from Room A because his belongings were not put away. CG further stated that Resident 1 seemed upset and told him that he had been sitting in the wheelchair for a while because staff left all his clothes and personal belongings on the bed. During an interview on 1/6/2026, at 12:07 PM, Licensed Vocational Nurse 1 (LVN 1) stated that the CNAs assigned to Resident 1 should have assisted with the move and put away the resident's clothes and personal belongings immediately so that the resident was not left sitting in a wheelchair for too long, to prevent discomfort. During an interview on 1/6/2026, at 12:20 PM, CNA 2 stated that she remembered Resident 1 being moved to his new room in Station B on 12/11/2025 but did not recall the exact time. CNA 2 stated that she did not remember putting the resident's clothes and personal belongings away and thought she might have been busy. CNA 2 added that CNAs were supposed to place residents' belongings in the closet or drawers in the new room. CNA 2 further stated that CNAs should have had enough time to put Resident 1's clothes and personal belongings in the closet when the resident was moved at 1 PM so that he could return to bed if he wanted to. During an interview on 1/6/2026, at 12:54 PM, LVN 1 stated that the CNA should have helped put Resident 1's clothes and personal belongings in the closet instead of leaving them on the bed. LVN 1 added that all of Resident 1's clothes should have been placed in the closet and that the licensed nurse and CNA on the new station should have been aware that the resident had already been moved. During an interview on 1/6/2026, at 1:05 PM, the Maintenance Assistant (MA) stated that he placed all of Resident 1's clothes and personal belongings from his previous room onto his bed and moved the resident to his new room on 12/11/2025, at around 1 PM. MA stated that nursing staff saw him move the resident to Station B. MA further stated that the CNA assigned to Station B should have put Resident 1's clothes and personal belongings away, or the CNA from Station A should have followed the resident to his new room and organized his belongings. During an interview on 1/6/2026, at 1:17 PM, LVN 2 stated that she did not recall receiving a report from Station A about Resident 1's move and that this should have been communicated to her, as it was her responsibility to ensure the resident was settled in the new room. LVN 2 stated that it was not acceptable to leave Resident 1 sitting in a wheelchair waiting for staff to put his belongings away. LVN 2 further stated that the CNA from Station A should have followed the resident to Station B so that he would not remain in the wheelchair for an extended period. During an interview on 1/6/2026, at 3:04 PM, the MA stated that Resident 1's TV remote control was not compatible with his TV because the facility was using a universal controller. MA also stated that the facility did not have a remote control for Resident 1's specific TV brand. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and difficulty walking. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognitive skills for daily decision making. The MDS also indicated Resident 2 was dependent (helper does all the effort) with shower and required substantial/maximal assistance with lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 2 required partial/moderate assistance with oral, toileting, and personal hygiene and upper body dressing. The MDS also indicated Resident 2's activity preference to keep up with the news was very important. During a concurrent observation and interview on 1/6/2026, at 1:35 PM, Resident 2 was lying in bed and stated that not all TV channels worked. Resident 2 turned on a news channel, which displayed a blurred screen, and then switched to a different channel (channel 5), which was also unclear compared to other channels. Resident 2 stated that it bothered her not to be able to watch those news stations. During an interview on 1/6/2026, at 3:04 PM, the MA stated that CNN and Channel 5 on Resident 2's TV did not work and that he had informed the Administrator (ADM) about (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the problem. MA also stated that he had been trying to get facility management to change the cable service/company to resolve the issue. During an interview on 1/6/2026, at 5:30 PM, the Director of Nursing (DON) stated that the TV remote control should be functional, and all channels should work so that residents can watch the programs they want. During a review of the facility's Policy and Procedure (P&P) titled, Accommodation of Needs, revised March 2021, the P&P indicated that the facility environment and staff behaviors are directed toward assisting the residents in maintaining and/or achieving safe independent functioning, dignity and well-being. The P&P also indicated that the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. During a review of the facility's P&P titled, Homelike Environment, revised February 2021, the P&P indicated that the facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which include a clean, sanitary and orderly environment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Restorative Nursing Assistant (RNA- responsible for providing restorative and rehabilitation care for residents/patients to maintain or regain physical, mental, and emotional well-being) services on 12/22/2025, 12/26/2025, and 1/2/2026 for one (1) of 1 sampled resident (Resident 1) with limited range of motion (ROM - movement of the joints) in accordance with the physician's order. This deficient practice had the potential to cause complications such as pain, swelling, and contractures) to Resident 1.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 bilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip and presence of right artificial knee joint. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 9/11/2025, the MDS indicated Resident 1 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with shower and required partial/moderate assistance (helper does less than half the effort) with lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 1 required supervision (helper provides cues) with oral and toileting hygiene and upper body dressing and required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 1's Physicians Order, dated 12/15/2025 timed at 3:38 PM, the Physicians Order indicated an RNA order for ambulation daily, three times a week (3x/week), 60 feet with front wheeled walker and gait belt (a sturdy strap with a buckle, worn around a person's waist to help caregivers safely support and guide individuals with balance or mobility issues, preventing falls during walking or transfers) as tolerated by resident. During a concurrent interview and record review with RNA 1 on 1/6/2026 at 4:27 PM, the RNA documentation report for December 2025 and January 2026 was reviewed. RNA 1 stated that RNA services were missing on 12/22/2025, 12/26/2025, and 1/2/2026.During a concurrent observation and interview on 1/6/2026 at 10:38 AM, Resident 1 was sitting at the side of the bed and stated he was supposed to receive RNA sessions three times per week, but they never came as scheduled.During a concurrent interview and record review of the RNA log on 1/6/2026 at 5:10 PM with the Director of Staff Development (DSD), the DSD stated the RNA log did not indicate that RNA services were provided on 12/22/2025, 12/26/2025, and 1/2/2026 and was unable to provide documented evidence that they were otherwise provided. DSD confirmed the resident only received one RNA service during the week of 12/22/2025 to 12/28/2025 and two sessions during the week of 12/29/2025 to 1/4/2026. DSD stated that RNA services for Resident 1 should be consistently provided as scheduled to maintain functional mobility and prevent decline. DSD further stated that if RNA services were not documented, it means they were not done.During an interview on 1/6/2026 at 4:53 PM, the Director of Nursing (DON) stated RNA services are important because they help maintain residents' mobility and could potentially cause a decline if not done consistently as ordered.During another interview on 1/7/2026 at 8:10 AM, the DON stated Resident 1 did not have a Care Plan for RNA services, which should have been in place to guide nurses in managing and providing care to the resident.During a review of the facility's Policy and Procedure (P&P) titled Restorative Nursing Services, revised July 2017, the P&P indicated that residents would receive restorative nursing care as needed to help promote optimal safety and independence. The P&P also stated that restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care.