

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 03/25/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure concerns were addressed for two (2) of 2 sampled residents (Resident 1 and 2) when the facility was informed of a resident (Resident 3) not allowing Certified Nursing Assistants (CNAs) to take water from the shared restroom in Room C to provide care for Resident 3's previous roommates and for the previous roommates to use the restroom. This deficient practice violates Resident 1 and 2's rights to be heard and for the resident's previous roommate to have the same access to services/ facility's amenities. Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/13/2026, the MDS indicated Resident 1 had intact skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with putting on/taking off footwear and required supervision (helper provides cues) with lower body dressing and personal hygiene. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with eating, oral and toileting hygiene, shower and upper body dressing. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). 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 required partial/moderate assistance with shower and required supervision with lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 2 required setup assistance with oral, toileting, and personal hygiene, and upper body dressing. 3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COPD and history of fall. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had intact cognitive skills for daily decision making. The MDS also indicated Resident 3 required setup assistance with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 3 was independent (resident completes the activity by themselves with no assistance from helper) with eating, oral and personal hygiene and upper body dressing. During a record review of the census for midnight of 3/24/2026, it indicated Resident 3's room (Room C) consisted of 2 beds in a room. The census also indicated Resident 2 was in Room A which was next to Room C. During a concurrent observation and interview on 3/25/2026 at 1:30 PM, Resident 1 was observed in her room seated on the wheelchair. Resident 1 stated Resident 3 would not allow her (Resident 3) roommates to use the bathroom in Room C and send the previous roommates to other rooms. Resident 1 also (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>stated she used to be roommates with Resident 3 in Room C, and Resident 3 would not let Resident 1 use the call light button (call system used to alert staff if the resident needed assistance) and the restroom. Resident 1 further stated he spoke to the Administrator (ADM) about the concern and had also brought it up at the resident council (an independent, organized group of nursing home residents who meet regularly to discuss concerns, offer suggestions, and plan activities to improve their quality of life and care) meeting recently (unable to recall when) and was also mentioned in the previous resident council meetings (unable to recall dates) but does not feel the concern was heard. Resident 1 stated the facility would not give Resident 3 a roommate because she (Resident 3) would raise a fuss about having a roommate. During a concurrent observation in Room A (room is next to Room C) and interview on 3/25/2026 at 2 PM, Resident 2 was seated on the wheelchair. Resident 2 stated Resident 3 would not let any of her (Resident 3's) roommates use the shared restroom in Room C and would not let CNAs use the bathroom to get water to clean Resident 3's previous roommates. Resident 2 further stated the CNAs would come to Room A and use Room A's restroom to get water to bathe Resident 3's previous roommate. Resident 2 further stated the Activity Director (AD) knew about the concerns during resident council meetings, but nothing has been done yet. During an interview on 3/25/2026 at 2:31 PM, Certified Nursing Assistant 1 (CNA 1) stated she had to get water from Room A or Room B's restrooms because Resident 3 would not let the CNA use the Room C restroom to get water to give Resident 3's previous roommate a bath. CNA 1 also stated the Director of Staff Development (DSD), the charge nurses and the ADM were all aware of the issue. CNA 1 further stated if Resident 3's roommate had the capacity to walk, that resident would not use the restroom because Resident 3 would tell that resident to use another residents' restroom. During an interview on 3/25/2026 at 2:52 PM, the Social Services Director (SSD), SSD stated Resident 3's previous roommates who had the ability to use the restroom complained about not being allowed to use the restroom in Room C and often requested to move to another room. SSD further stated it was not acceptable to have Resident 3's roommate use another resident's restroom because they also have the same rights to be able to use Room C's restroom. During an interview on 3/25/2027 at 3:30 PM, CNA 2 stated Resident 3 sometimes would not allow CNA 2 to use Room C's restroom anytime CNA 2 provided personal hygiene to Resident 3's previous roommate. During an interview on 3/25/2026 at 3:30 PM, the Director of Nursing (DON) stated she heard about the shared bathroom complaints during one of the recent resident council meetings (unable to remember when) but had not yet spoken to Resident 3. The DON also stated, normally she would talk to Resident 3 and sit down with her (Resident 3) and explain that all the residents in the same room (Room C) as the resident had the right to use the restroom in Room C. The DON further stated the SSD should have talked to the residents concerned during the resident council meeting. The DON also stated there should have been a follow up to the residents who raised their concerns and a closure/ provided them with the resolution to the complaints. During an interview on 3/25/2026 at 4:56 PM, the DON stated the CNAs should be able to use Room C's restroom to get water for Resident 3's roommate because that was a shared restroom and the roommate also has the right to use it. During an interview on 3/25/2026 at 4:38 PM, the Registered Nurse 1 (RN 1) stated he had heard about a resident not allowing CNAs to get water from the shared restroom between the roommates to provide care to the roommate. RN 1 also stated the resident's roommate has the right to use the restroom and should be allowed to get water from there because it is a shared restroom. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised 2/2021, the P&P indicated that Federal and state laws guarantee certain basic rights to all residents of this facility and these rights include the resident's right to communication with and access to people and services, both inside and outside the facility, voice grievances to the facility and have the facility respond to his or her grievances.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's environment was free from accident hazards for one (1) of 2 sampled residents (Resident 3) when three (3) oxygen tanks (a metal canister storing compressed, 100 percent pure oxygen for people with breathing difficulties) was found inside the resident's restroom and two (2) oxygen tanks outside the resident's restroom located close to the wall by the left side of the resident's room were not removed when not in use as indicated in the facility's policy. This deficient practice had the potential to result in injuries and serious harm in the event of a resident fall (to drop or descend under the force of gravity, as to a lower place through loss or lack of support). Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and history of fall. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 3 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 3 required setup assistance (helper sets up; resident completes activity) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 3 was independent (resident completes the activity by themselves with no assistance from helper) with eating, oral and personal hygiene and upper body dressing. During a review of Resident 3's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall) dated 3/3/2026 indicated Resident 3 was at risk for fall. During an observation on 3/25/2026 at 3:47 PM of Resident 3's room with Certified Nursing Assistant 1 (CNA 1), there were 3 oxygen tanks seen in the resident's restroom and 2 outside the resident's restroom close to the wall by the left side of the resident's room. During a concurrent observation and interview on 3/25/2026 at 3:52 PM, Licensed Vocational Nurse 1 (LVN 1) inside Resident 3's room, LVN 1 stated, Resident 3 had so many oxygen tanks inside the resident's room and the resident's restroom. LVN 1 also stated the 3 oxygen tanks in the resident's restroom and 2 oxygen tanks by the food of the resident's bed should be removed because it could become a safety hazard for Resident 3. During an interview on 3/25/2026 at 4:38 PM, Registered Nurse 1 (RN 1) stated oxygen tank should be stored in the oxygen storage room if not being used and not inside the resident's room. RN 1 also stated there should only be 1 oxygen tank inside Resident 3's room that is for the resident's use. RN 1 further stated 5 oxygen tanks inside the resident's room should not be allowed because it is a safety issue and a trip hazard for the residents. During an interview on 3/25/2026 at 4:56 PM, the Director of Nursing (DON) stated the 5 oxygen tanks stored inside Resident 3's room were a big hazard to Resident 3 because the resident could trip, fall and might hit her (Resident 3) head on the oxygen tank. The DON further stated oxygen tanks should be stored and placed in the oxygen storage room because it is a fire hazard and should not be stored in the resident's room. During a review of the facility's Policy and Procedure (P&P) titled, Fire Safety and Prevention, revised May 2011, it indicated its purpose was to ensure all personnel must learn methods of fire prevention and must report condition (s) that could result in a potential fire hazard. The P&P also indicated not to store oxygen cylinders in any resident's room or living areas. During a review of the facility's P&P titled, Safety and Supervision of Resident, revised July 2017, it indicated the facility strives to make the environment as free from accident hazards as possible. The P&P also indicated that the resident's safety and supervision and assistance to prevent accidents are facility-wide priorities.</p>		