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	06/11/2026

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 - Few	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 interview and record review, the facility failed to inform about one of three sampled residents (Resident 1) the resident's rights and responsibilities to participate in her care and treatment in accordance with the facility's policy This deficient practice has resulted in Resident 1 feeling disrespected and has a potential effect on Resident 1's sense of self-worth and self-esteem which could result in problems with emotional and mental well-being.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body), cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting the left dominant side, major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems), hypertension (high blood pressure) and abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], 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, sit to stand, chair/bed-to -chair transfer, toilet transfer and tub/shower transfer. During a review of Resident 1's Advance Beneficiary Notice of Non-coverage (ABN Form CMS-R-131, is issued by providers to original Medicare [fee for service - FFS] beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances) dated [DATE] was reviewed. The ABN Form indicated Resident 1 maximized her benefits for the skilled therapy services (rehabilitation treatments provided by or under the direct supervision of licensed professionals such as physical[help individuals recover from injury, manage chronic pain, and improve mobility or physical function], occupational [helps people of all ages develop, recover, or maintain the skills needed for daily living and working], or speech therapists[clinical treatment that improves a person's ability to talk, understand language, use their voice, and swallow safely]) . During a concurrent interview and record review on [DATE] at 12:01 PM with Resident 1, Resident 1's ABN Form dated [DATE] was reviewed. Resident 1 stated Director of Rehab (DOR) came into her room and asked her to sign the ABN Form. Resident 1 stated she did not ask questions to the DOR because she could not fully understand what was written on the ABN form and DOR marked option 3 before the resident signed the ABN Form. Resident 1 thought she was expected to sign the ABN form and so she signed the form without fully understanding it. Resident 1 was not aware that she could write an appeal regarding the changes to her Physical Therapy (PT, is a medical treatment used to restore functional movements, such as standing, walking, and moving different body parts) treatment or ABN form. During an interview on [DATE] at 1:22 PM, DOR stated, DOR did not inform Resident 1's (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Responsible Party 1 (RP 1) regarding the issue on Resident 1's PT schedule or changes in the resident's treatment. DOR stated Resident 1's RP 1 should be notified with the change of treatment for Resident 1. During a concurrent interview and record review on [DATE] at 10:35 AM with the Business Office Manager (BOM), Resident 1's ABN Form dated [DATE] and [DATE] were reviewed. BOM stated Resident 1's ABN Form indicated expiration date [DATE]. BOM stated if ABN form was the expired version, the ABN Form was not valid. BOM also stated they need to revise the ABN Form for Resident 1 and use the updated version which indicates an expiration date of [DATE]. During an interview on [DATE] at 10:41 AM with the Director of Nursing (DON), the DON stated if the facility used an expired version of the ABN form, it means the form was not updated and it is not valid During a concurrent interview and record review on [DATE], at 3:40 PM, with the DON, Resident 1's Interdisciplinary Team (IDT - group of healthcare professionals from different clinical and support disciplines (such as doctors, nurses, therapists, and social workers) who collaborate to evaluate, plan, and deliver unified care for a patient) Notes dated [DATE] to [DATE] were reviewed. The DON stated there was no IDT Meeting conducted for Resident 1's change of treatment/ physical therapy order. The DON also stated SSD did not have any IDT meeting for Resident 1 since last year (2025) nor with RP 1. During an interview on [DATE] at 4:05 PM with RP 1, RP 1 stated she was not aware of the PT therapy issue or the maximized benefits for Resident 1's treatment. RP1 also stated they have not had IDT with the facility for many months, and the last one was last year (2025). RP 1 added the facility did not inform her about the ABN form that Resident 1 signed. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights, revised 2/2021, P&P indicated, federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:> be informed about his or her rights and responsibilities;be notified of his or her medical condition and of any changes in his or her condition.be informed of, and participate in, his or her care planning and treatment. During a review of Centers for Medicare & Medicaid Services, (CMS, provides health coverage to residents through Medicare, Medicaid) Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) Office of Management and Budget (OMB) Approval Number: 0938-0566 modified [DATE], the FFS ABN indicated:1. On [DATE] the updated ABN is effective now and expires [DATE]. Providers may continue to use the expired version of the ABN until [DATE] but must transition to the approved form no later than that date.2.The ABN Forms instructions also indicated Notifiers must: Deliver the ABN to the patient(resident) or their representative before providing the items or services. Review the ABN with the patient or their representative and answer any questions before it' is signed Deliver the ABN far enough in advance that the patient or representative has time to consider the options and make an informed choice. Give a copy to the patient or representative, if requested, once all blanks are completed and the form is signed.https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abnhttps://www.cms.gov/