

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  01/17/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42223</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 49) was treated with respect and dignity in accordance with the facility policy by failing to ensure by failing to keep the resident's clothes clean and free of food particles.</p> <p>This deficient practice has the potential to affect the resident's self-worth and self-esteem.</p> <p>Findings:</p> <p>During a review of Resident 49's Admission Record, the Admission Record indicated resident was admitted to the facility on [DATE] with the following diagnoses of muscle weakness and spinal stenosis (space inside the backbone is too small).</p> <p>During a review of Resident 49's History and Physical (H&amp;P), dated 10/22/2024, the H&amp;P indicated resident has the capacity to understand and make decisions.</p> <p>During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool), dated 10/24/2024, the MDS indicated resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated Resident 49 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating and required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper body dressing. Resident was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear.</p> <p>During a concurrent observation in the resident's room and interview on 1/14/2025 at 8:50 AM, Resident 49's clothes was observed with yellow particles. Resident 49 was observed picking the food particles on his clothes while stating the food on his clothes bugs him.</p> <p>During a concurrent observation and interview on 1/14/2025 at 8:57AM, Registered Nurse 1 (RN 1) stated there were eggs on Resident 49's clothes. RN 1 stated there should not be any food particles on the resident's shirt because resident should be treated with dignity.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 11:12AM, the Director of Nursing (DON) stated there should not be any food on residents' clothes because it was important to keep them clean and it was a way of treating the residents with dignity.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Dignity, revised 2/2021, the P&amp;P indicated residents are provided with a dignified dining experience. P&amp;P also indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</b></p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 88) was informed in advance, of the risks and benefits of proposed care by failing to obtain an informed consent prior to the use of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness, or behavior) in accordance with the facility policy.</p> <p>This deficient practice had the potential for Resident 88 not to be able to exercise the right to choose the resident's treatment plan.</p> <p>Findings:</p> <p>During a review of Resident 88 Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of unspecified fracture of the left fibula (calf bone), dislocation of the left ankle joint, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints) and unsteadiness on feet.</p> <p>During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool), dated 12/27/2024, the MDS indicated resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with roll left and right, sit to lying, lying to sitting on side of bed and toilet transfer. Resident also was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with sit to stand and chair/bed to chair transfer. MDS indicated Resident 88 was taking an antianxiety medication.</p> <p>During a review of Resident 88's Care plan with focus on Lorazepam, dated 12/26/2024, the care plan indicated to educate the resident about risks, benefits, and the side effects and/ or toxic symptoms of medication.</p> <p>During a record review of Resident 88's 1/2025 Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident. ), indicated resident was administered Lorazepam (used to treat anxiety disorders [fear characterized by behavioral disturbances]) on 1/16/2025.</p> <p>During a concurrent interview and record review of Resident 88's medical records on 1/16/2025 at 10:20 AM, MDS Coordinator stated Resident 88 did not but should have had a consent for Lorazepam prior to use.</p> <p>During an interview on 1/16/2025 at 2:10 PM, Resident 88 stated he did not give or sign a consent for Lorazepam.</p> <p>(continued on next page)</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 3:08 PM, the Director of Nursing (DON) stated the facility should obtain a consent from the resident/responsible party prior to placing an order for psychoactive medication.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Resident Rights, revised 2/2021, the P&amp;P indicated federal and state laws guidance certain basic rights to all residents of this facility which includes for the resident to be informed of, and participate in, his or her care planning and treatment.</p>		

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<p>F 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure 10 of 43 resident rooms (Rooms: A, B, C, D, E, F, G, H, I, and J) were free of chipped/ peeling paint and unpainted patched areas in accordance with the facility policy.</p> <p>This deficient practice had the potential for unsafe and unclean resident's environment with the potential to place residents at risk for physical discomfort.</p> <p>Findings:</p> <p>During an observation on 1/14/2025 at 8:06 AM, the wall on the head part of two beds in the middle of Room B had white patched area over the old paint measuring approximately 16 inches x 11 inches.</p> <p>During an observation on 1/14/2025 at 3:36 PM, the wall directly behind the head part of the bed in Room C had a large white patched area over the old paint measuring approximately 5 feet x 1.5 feet. The foot part had a large white patched area over the old paint measuring approximately 14 inches x 12 inches.</p> <p>During an observation on 1/15/2025 at 9:42 AM, the wall on the right side close to Bed-2 in Room D had a large white patched area over the old paint measuring approximately 12 inches x 14 inches.</p> <p>During a concurrent observation with the Maintenance Supervisor (MS) on 1/15/2025 at 3:22 p.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. Room E had peeling paint behind the head of the bed of bed 1.</li> <li>2. Room F had chipped paint on the right side of resident's bed</li> <li>3. Room G had chipped paint behind the head of the bed of bed 1 and bed 2.</li> </ol> <p>During an observation on 1/17/2025 at 1:46 PM, the following were observed:</p> <ol style="list-style-type: none"> <li>1. Room H's wall had a chipped paint behind the head of the bed of bed 1 and bed 2</li> <li>2. Room I's wall had chipped paint behind the head of the bed of bed 1.</li> </ol> <p>During an observation on 1/17/2025 at 1:55 PM, the following were observed:</p> <ol style="list-style-type: none"> <li>1. Room A's wall, by the television area, had peeling paint.</li> <li>2. Room J's wall had chipped paint by the head of the bed of bed 1.</li> </ol> <p>During an interview with the MS on 1/15/2025 at 3:38 PM, MS stated that the wall should be painted so it would look nice and feel homelike for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview with Director of Nursing (DON) on 1/17/2025 at 9:18 AM, the DON confirmed multiple areas inside some of the residents' rooms needed repainting. The DON stated it was not considered homelike and should be painted by maintenance department.</p> <p>During an interview with Administrator (ADM) on 1/17/2025 at 3:23 PM, ADM confirmed that Rooms A, B, C, D, E, F, G, H, I, and J had chipped paint and/or peeling paint on the wall and should be repainted. ADM stated he was aware that the facility environment needed a lot of areas to be fixed and was working on it.</p> <p>During a review of facility's Policy and Procedure titled, Homelike Environment, revised 2/2021, the P&amp;P indicated that residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The policy also indicated that the facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting.</p> <p>During a review of the facility's P&amp;P titled, Maintenance Service, revised 12/ 2009, indicated that maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy also indicated that the functions of maintenance personnel include but are not limited to maintaining the building in good repair.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 77) who were unable to carry out activities of daily living (ADL) received the necessary care and services to maintain good personal hygiene.</p> <p>This deficient practice had the potential for unmet resident's needs, which can result to a decline in physical and emotional well-being.</p> <p>Findings:</p> <p>During a review of Resident 77's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness, difficulty walking, and neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems).</p> <p>During a review of Resident 77's Care Plan, initiated on 10/4/2024, the Care Plan indicated a focus on Resident 77's bowel incontinence and an approach plan to assist the resident with toileting needs every shift.</p> <p>During a review of Resident 77's Minimum Data Set (MDS- a resident assessment tool), dated 12/27/2024, the MDS indicated Resident 77 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 11 was dependent (helper does all the effort) with lower body dressing and putting on/taking off footwear and required substantial assistance (helper does more than half the effort) with toileting and personal hygiene, shower, and upper body dressing. The MDS further indicated Resident 11 had frequent bowel incontinence (involuntary loss of bowel control).</p> <p>During an observation in Resident 77's room and interview on 1/14/2024 at 9:08 AM, Resident 77 turned on the call light and requested Certified Nursing Assistant 3 (CNA 3) for a diaper change.</p> <p>During an observation on 1/14/2024 at 9:13 AM, CNA 3 was seen with a Hoyer lift (a patient lift used by caregivers to safely transfer patients) and proceeded to enter another resident's room (Room C) to assist a CNA.</p> <p>During an observation on 1/14/2024 at 9:15 AM, Resident 77 turned on the call light and was answered by Central Supply Director (CSD) who then proceeded to look for CNA 3.</p> <p>During an observation on 1/14/2024 at 9:17 AM, CNA 3 was notified by CSD upon exiting Room C that Resident 77 had requested a diaper change. CNA 3 told Resident 77 to hold on and that she will be right back.</p> <p>During an observation on 1/14/2024 at 9:20 AM, CNA 3 went back to Room C to change the bed sheets on Bed 1.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/14/2024 at 9:24 AM, Resident 77 turned on her call light for the 3rd time and was answered by the Infection Prevention Nurse (IPN). Resident 77 told IPN she was looking for her CNA to get her diaper changed.</p> <p>During an observation on 1/14/2024 at 9:30 AM, Resident 77 received assistance from CNA 3.</p> <p>During an interview on 1/15/2024 at 2:28 PM, CNA 3 stated she should have changed Resident 77's diaper before fixing and changing the bed sheets in Room C Bed 1. CNA 3 also stated she should have prioritized assisting Resident 77.</p> <p>During an interview on 1/15/2024 at 2:40 PM, Registered Nurse 1 (RN 1) stated CNA 3 should have assisted Resident 77 instead of doing other tasks. RN 1 also stated Resident 77 could potentially develop skin breakdown if seated on soiled diaper for an extended period.</p> <p>During a concurrent observation in Resident 77's room and interview on 1/15/2024 at 3:43 PM, Resident 77 stated she wanted assistance from staff but was unable to find her call light.</p> <p>During an interview on 1/17/2025 at 9:39 AM, the Director of Nursing (DON) stated the staff should prioritize resident care and attend to the residents need for assistance right away (within five minutes).</p> <p>During a review of the facility's Policy and Procedure titled, Accommodation of Needs, revised March 2021, indicated that the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The policy 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.</p> <p>During a review of the facility's Policy and Procedure titled, Activities of Daily Living (ADL), Supporting, revised March 2018, indicated that the residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42223</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 88) was free of accident hazards by failing to provide a wheelchair with tires that were not torn.</p> <p>This deficient practice has the potential to cause injury and/or fall to Resident 88.</p> <p>Findings:</p> <p>During a review of Resident 88 Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of unspecified fracture of the left fibula (calf bone), dislocation of the left ankle joint, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints), and unsteadiness on feet.</p> <p>During a review of Resident 88 History and Physical (H&amp;P), dated 12/26/2024, the H&amp;P indicated resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool), dated 12/27/2024, the MDS indicated resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated Resident 88 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling from left and right, sit to lying, lying to sitting on side of bed and toilet transfer. Resident also is dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with sit to stand and char/bed to chair transfer.</p> <p>During an observation and interview on 1/14/2025 at 8:35 AM in Resident 88's room, Resident 88 stated that the breaks of his wheelchair does not work very well. Resident 88's wheelchair tires were both observed torn.</p> <p>During an observation on 1/14/2025 at 12 PM, Resident 88 was observed using the wheelchair in the hallway and had a hard time stopping the wheelchair.</p> <p>During an observation and interview on 1/16/2025 at 10:58 AM near the nursing station, Maintenance Supervisor (MS) stated when there were damages in the tires of Resident 88's wheelchair. MS stated the staff brings any damaged wheelchair to him or to the Maintenance Assistant (MA). MS also stated that he was not informed about the wheelchair tires being torn. MS stated if the resident uses the wheelchair in that condition, it will not be safe for the resident to use because it is a potential for fall and injury.</p> <p>During an interview on 1/16/2025 at 11:04 AM, the Director of Nursing (DON) stated the tires on Resident 88's wheelchair were damaged which was a potential for fall and injury. The DON also stated it is not safe to use the wheelchair in that condition and it needed to be changed.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Maintenance Service, revised 12/2009, the P&P indicated maintenance department is responsible for maintaining equipment in a safe and operable manner at all times. The P&P also indicated the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49537</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care services for one of one sampled resident (Resident 294) by failing to ensure oxygen (O<sub>2</sub>, a colorless, odorless gas necessary for most living organisms to breathe and function properly) was administered according to the physician's orders.</p> <p>This deficient practice placed Resident 294 at risk for experiencing complications such as respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing, rapid breathing, and low blood oxygen level) that can lead to serious illness and/or death.</p> <p>Findings:</p> <p>During a review of Resident 294's Admission Record, the Admission Record indicated the facility admitted the resident on 1/6/2025 with diagnoses that included acute and chronic respiratory failure (loss of the ability to ventilate adequately or to provide sufficient oxygen to the blood and multiple organs) with hypercapnia (excessive CO<sub>2</sub> in the blood stream typically caused by inadequate respiration), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic diastolic congestive heart failure (CHF-a condition where the left ventricle of the heart becomes stiff and does not relax properly between beats, hindering its ability to fill with blood), abnormalities in gait and mobility (gait refers to a way a person walks or runs, while mobility is the ability to move around), and unsteadiness on feet (trouble with balance or walking).</p> <p>During a review of Resident 294's Medication Administration Record (MAR-a report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional) for the month of January 2025, the MAR indicated O<sub>2</sub> at 2 liter per min (LPM- unit of measurement for oxygen a patient receives) via nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously every shift with order date of 1/6/2025.</p> <p>During a review of Resident 294's Minimum Data Set (MDS-a resident assessment tool), dated 1/11/2025, the MDS indicated Resident 294 had moderate cognitive (mental processes that take place in the brain, including thinking, attention, language learning, memory, and perception skills for daily decision making) impairment. The MDS also indicated Resident 294 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating and oral hygiene and required partial/moderate assistance (Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) with upper body dressing and personal hygiene. The MDS also indicated Resident 294 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathing self and lower body dressing and was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene and putting on/taking off footwear, sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), chair/bed-to-chair (ability to transfer to and from a bed to a chair or wheelchair), and toilet transfer (ability to get on and off a toilet or commode).</p> <p>(continued on next page)</p>		

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  01/17/2025
NAME OF PROVIDER OR SUPPLIER  Huntington Drive Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  400 W. Huntinton Dr. Arcadia, CA 91007	

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 294's Care Plan, initiated on 1/16/2025, the Care Plan indicated Resident 294 had O2 therapy related to COPD, hypercapnic respiratory failure, and CHF with interventions that included O2 via nasal prongs (also known as nasal cannula [NC]) at 2L continuously.</p> <p>During an observation on 1/14/2025 at 8:39 AM, outside Resident 294's room, Certified Nurse Assistant 6 (CNA 6) was observed wheeling resident back from the restroom. Resident 294 did not have her NC on her nostrils. CNA 6 positioned the wheelchair on the left side of the bed and left the room.</p> <p>During a concurrent observation and interview on 1/14/2025 at 8:42 AM, in Resident 294's room, NC tubing was observed on top of the pillow on the right side of the bed which was not within reach of the resident. Resident 294 stated she went to the restroom and was assisted by CNA 6. CNA 6 did not place her NC back to her nostrils after. Resident 294 pushed her call light and was answered by the Director of Staff Development (DSD). The DSD asked what resident needed and Resident 294 pointed to her NC and stated to put it back in her nostrils.</p> <p>During an interview on 1/17/2025 at 9:23 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated Resident 294's O2 order via NC was continuous. LVN 3 stated, if O2 was not put back after the resident used the restroom, that was no longer following the physician's order of continuous. LVN 3 stated it was important to follow the physician's order to prevent shortness of breath and other complications and ending up calling 911 (telephone number used to reach emergency medical, fire, and police services). LVN 3 stated that CNA 6 should have notified the charge nurse so charge nurse can also assess the resident after being off her O2 while using the restroom.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled Oxygen Administration, revised on February 2024, the P&amp;P indicated the purpose is to provide guidelines for safe oxygen administration. The P&amp;P also indicated to verify that there is physician's order, to review the physician's order or facility protocol for oxygen administration. The P&amp;P also indicated to review the resident's care plan to assess for any special needs of the resident.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099</b></p> <p>Based on observation, interview, and record review, the facility failed to implement the physician's order for fluid restriction of 1200 cubic centimeters (cc - units of volume on liquids) a day by ensuring accurate monitoring of the resident's fluid intake for one of 2 sampled residents (Resident 38) with a diagnoses that included end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) with dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>This deficient practice had the potential to place the resident at risk for fluid overload (a condition where the body has too much fluid).</p> <p>Findings:</p> <p>During a review of Resident 38's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses that included end stage renal disease with dependence on renal dialysis.</p> <p>During a review of Resident 38's Care Plan initiated on 12/2/2024, the Care Plan indicated a focus on Resident 38's fluid restriction and an approach plan to restrict fluids to 1200 cc/24 hours which included the breakdown as follows:</p> <ol style="list-style-type: none"> <li>1. Dietary - 840 cc/24 hours             <ol style="list-style-type: none"> <li>a) Breakfast - 360 cc</li> <li>b) Lunch - 240 cc</li> <li>c) Dinner - 240 cc</li> </ol> </li> <li>2. Nursing - 360 cc/24 hours             <ol style="list-style-type: none"> <li>a) 7-3 pm - 120 cc</li> <li>b) 3-11pm - 120 cc</li> <li>c) 11-7 am - 120 cc</li> </ol> </li> </ol> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 38's Minimum Data Set (MDS- a federally mandated assessment tool), dated 12/5/2024, the MDS indicated Resident 38 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 38 was dependent (helper does all the effort) with toileting, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 38 required substantial assistance (helper does more than half the effort) with upper body dressing and personal hygiene and required partial assistance (helper does less than half the effort) with oral hygiene.</p> <p>During a review of Resident 38's physician's order, dated 12/30/2024, the physicians order indicated an order for 1200 cc/24 hours fluid restriction broken down to Dietary = 840 cc/24 hours and Nursing = 360 cc/24 hours.</p> <p>During a review of Resident 38's CNAs documentations of summary of fluids consumed from 1/13/2025 to 1/16/2025, the document indicated the following:</p> <ol style="list-style-type: none"> <li>1. Missing entry for fluids consumed around breakfast on 1/13/2025, 1/14/2025, 1/15/2025, and 1/16/2025.</li> <li>2. Fluids consumed on 1/13/2025 indicated 280 cc at 12:40 PM as opposed to 240 cc.</li> <li>3. Fluids consumed on 1/13/2025 indicated 260 cc at 6:03 PM as opposed to 240 cc.</li> <li>4. Fluids consumed on 1/14/2025 indicated 260 cc at 1:27 PM and 1:28 PM for a total of 520 cc as opposed to 240 cc.</li> <li>5. Fluids consumed on 1/14/2025 at 5 PM indicated a total of 300 as opposed to 240 cc.</li> <li>6. Fluids consumed on 1/15/2025 at 1:27 PM indicated a total of 260 as opposed to 240 cc.</li> <li>7. Fluids consumed on 1/15/2025 at 5 PM indicated a total of 260 as opposed to 240 cc.</li> <li>8. Fluids consumed on 1/16/2025 at 2:07 PM and 2:08 PM indicated a total of 480 as opposed to 240 cc.</li> </ol> <p>During a concurrent observation and interview on 1/14/2025 at 4:26 PM, Resident 38 was in bed with a full pitcher of water (approximately 1000 cc) and a glass of water (approximately 50 cc) at his bedside table.</p> <p>During an interview on 1/15/2025 at 9:35 AM, Resident 38 stated he thought he was on fluid restriction but was provided with pitchers of water each morning and was refilled by the staff throughout the day.</p> <p>During an interview on 1/16/2025 at 11:06 AM, Licensed Vocational Nurse 1 (LVN 1) confirmed Resident 38 was on fluid restriction and could develop shortness of breath (SOB, difficulty breathing) if provided with too much fluid. LVN 1 also stated the staff should not have provided Resident 38 with a full pitcher of water at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 2:20 PM, the Certified Nursing Assistant 2 (CNA 2) stated Resident 38 was on fluid restriction but does not know how much. CNA 2 also stated the amount of fluid consumed by Resident 38 should be accurately documented to know how much fluid the resident had already received. CNA further stated Resident 38 should not have a full pitcher of water at bedside.</p> <p>During a review of the facility's Policy and Procedure titled, End-Stage Renal Disease, Care of a Resident with, revised September 2010, indicated that the residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The policy also indicated that the resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 19 sampled residents (Resident 15) was assessed for the use of bedside rails (adjustable metal or rigid plastic bars that attaches to the bed) in accordance with the facility's policy.</p> <p>This deficient practice placed the Resident 15 at risk for potential accident such as a body part being caught between the bedside rails, falls if a resident attempts to climb over, around, between, or through the bedside rails, which could result in injury, harm, and/or death.</p> <p>Findings:</p> <p>During a review of Resident 15's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included cerebral infarction (a lack of adequate blood supply to the brain cells), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and history of falling.</p> <p>During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 15 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 15 was dependent (helper does all the effort) with shower, lower body dressing and putting on/taking off footwear and required substantial assistance (helper does more than half the effort) with toileting and personal hygiene, and upper body dressing. The MDS further indicated Resident 15 required supervision (helper provides verbal cues) with oral hygiene and setup assistance (helper sets up; resident completes activity) with eating.</p> <p>During an observation on 1/14/2025 at 3:34 PM, Resident 15 was in bed sleeping with both right and left middle section of the bedside rails up.</p> <p>During a concurrent interview on 1/16/2025 at 11:41 AM and review of Resident 15's physicians order summary on the use of bilateral bedside rails as an enabler to aid in mobility, positioning, and transfer, the Minimum Data Set (MDS) Nurse confirmed the physicians order summary indicated the following:</p> <ol style="list-style-type: none"> <li>1. Ordered on 6/26/2023 and discontinued on 6/27/2023</li> <li>2. Reordered on 6/27/2024 and discontinued on 6/28/2023</li> <li>3. Reordered on 6/28/2023 and discontinued on 7/6/2023</li> <li>4. Reordered date on 7/7/2023 and discontinued on 7/13/2024</li> <li>5. Reordered on 10/27/2024 and discontinued on 5/11/2024.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MDS nurse also stated Resident 15 did not have a consent and should have a consent for the use of bedside rails. The MDS nurse further stated that Resident 15's family should have been asked for their consent before the resident's bedside rails was used.</p> <p>During an observation on 1/16/2025 at 12:25 PM, Licensed Vocational Nurse 1 (LVN 1) verified Resident 15 was in bed sleeping with both right and left middle section of the bedside rails up.</p> <p>During a concurrent interview on 1/17/2025 at 9:30 AM and review of Resident 15's medical record, the Director of Nursing (DON) confirmed Resident 15 did not have a consent for the use of the bedside rail and only had two Bedside Rail Utilization Assessment done dated 6/26/2023 and 11/1/2023. The DON stated the facility should have obtained a consent prior to the use of bilateral bedside rails and the family informed of the risk and benefits for its use. The DON further stated a Bedside Rail Utilization assessment for the use of bedside rails should have been done prior to each use to ensure its necessity and ensure there was no risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about).</p> <p>During a review of the facility's Policy and Procedure titled, Bed Safety and Bed Rails, revised August 2022, indicated that the use of bed rails is prohibited unless the criteria for the use of bed rails have been met including attempts to use alternatives, interdisciplinary (involves two or more professions) evaluation, resident assessment, and informed consent.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</b></p> <p>Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to ensure:</p> <ol style="list-style-type: none"> <li>1. Opened food items were labeled with used by date.</li> <li>2. To discard expired food in the kitchen.</li> </ol> <p>These deficient practices have the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization .</p> <p>Findings:</p> <p>During a concurrent initial kitchen tour observation and interview with Dietary Supervisor (DS) on [DATE] at 7:48 AM, DS stated several expired and opened items as follows did not have a proper label of open date and used by date:</p> <ol style="list-style-type: none"> <li>a. One (1) opened bottle of seasoning salt with label date of [DATE].</li> <li>b. 1 opened bottle of ginger ground with label date of [DATE].</li> <li>c. 1 opened bottle of pure vegetable oil with label date of [DATE].</li> <li>d. 1 opened bottle of browning and seasoning sauce expired on [DATE]</li> <li>e. 1 opened bottle of food coloring expired on [DATE].</li> </ol> <p>During a concurrent observation the walk-in refrigerator and interview with DS on [DATE] at 8:39 AM, DS stated several opened items as follows did not have a proper label of open date and used by date.</p> <ol style="list-style-type: none"> <li>f. six (6) opened plastic bags of pasta with label date of [DATE].</li> <li>g. two (2) plastic bags of chocolate cake mix with label date of [DATE].</li> <li>h. 2 cartons of thickened dairy drink with label date of [DATE].</li> </ol> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>DS stated she did not know why the observed food items were not labeled with delivery date and used by date, and why the expired items were still stored in the kitchen. DS stated expired items should have been discarded. DS stated the expired browning and seasoning sauce, and food coloring should have been discarded and not be kept or stored in the facility kitchen. DS stated, the items such as opened bottles of seasoning salt, ground ginger, pure vegetable oil, 6 opened plastic bags of pasta, 2 plastic bags of chocolate cake mix, and 2 cartons of thickened dairy drink were labeled with date, however DS stated she was not sure if the items were labeled with the delivery date or used by date. DS stated to prevent confusion among staff, staff should consistently use the same way of labeling all items with the delivery date and label all opened food items with the used by date to ensure food safety, and to minimize the risk of serving expired food, which could lead to foodborne illness.</p> <p>During a review of facility's undated policy and procedure (P&amp;P) titled, Storage of Food and Supplies, the P&amp;P indicated that no food will be kept longer than the expiration date on the product.</p> <p>During a review of facility's undated P&amp;P titled, General Receiving of Delivery of Food and Supplies, policy indicated label all items with the delivery date or a use-by date.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</b></p> <p>Based on interview and record review, the facility failed to ensure a coordination of care between facility and hospice (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) staff for one of one sampled resident (Resident 76) in accordance with the facility's hospice program by failing to ensure:</p> <p>a. Certified Home Health Agency (CHHA) staff followed physician's order to visit and provide care to Resident 76 twice (2) per week.</p> <p>b. Hospice care plan was developed for Resident 76.</p> <p>These deficient practices have the potential for Resident 76 to not receive the required hospice care and services necessary to promote comfort and quality of life.</p> <p>Findings:</p> <p>During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was originally admitted to the facility on [DATE]. Resident 76's diagnoses included cirrhosis of liver (permanent scarring that damages liver and interferes with its functioning), congestive heart failure (the heart does not pump blood as well as it should), and alcohol dependence.</p> <p>During a review of Resident 76's Minimum Data Set (MDS, a comprehensive assessment and care-screening tool), dated 12/25/2024, the MDS indicated Resident 76 was severely impaired with cognitive skills [ability to think, understand, and reason]) for daily decision making. The MDS indicated Resident 76 required substantial/maximal assistance (helper does more than half the effort) for eating, toileting hygiene, and personal hygiene. The MDS indicated Resident 76 had a chronic (long-term) disease that may result in a life expectancy of less than six (6) months and received hospice care while a resident in the facility.</p> <p>During a review of Resident 76's Physician's Order Summary with an order date of 12/21/2024, the Physician's Order Summary indicated that Resident 76 was under hospice.</p> <p>During a review of Resident 76's Physician's Certification for Hospice Benefit, dated 12/21/2024 to 3/20/2025, indicated CHHA frequency of visits was 2 times a week. The hospice binder also had a Staff Sign in Sheet indicated that CHHA signed in on dated 12/27/2024, 12/31/2024, 1/4/2025, 1/10/2025, and 1/14/2025.</p> <p>During an interview with the Director of Nursing (DON) and record review of Resident 76's Hospice binder on 1/15/2025 at 11:12 AM, the DON stated Resident 76 has been admitted to hospice since 12/21/2024. The DON acknowledged the physician order indicated the frequency of CHHA visit was 2x a week. The DON stated that CHHA visited only once a week during the weeks of 12/22/2024 to 12/28/2024 and 1/5/2025 to 1/11/2025. The DON stated Resident 76's hospice binder did not have a hospice care plan for Resident 76.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview with Director of Patient Care Service (DPCS) on 1/16/2025 at 12:43 PM, DPCS validated that CHHA missed one visit during the week of 12/22/2024 to 12/28/2024 and missed one visit during the week of 1/5/2025 to 1/11/2025. DPCS stated it was important that hospice staff followed the physician order so Resident 76 received the required hospice care and services necessary to promote his comfort and quality of life. DPCS stated each resident on hospice had their own binder which contains all of the Resident's records, including the hospice care plan. DPCS stated it was important to have the care plan on file, so hospice staff know how to provide care to the hospice resident.</p> <p>During a review of the facility's policy and procedure titled, Hospice Program, revised in July 2017, the policy and procedure indicated that the facility would coordinate care plan for resident receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.</p>

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  01/17/2025
NAME OF PROVIDER OR SUPPLIER  Huntington Drive Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  400 W. Huntinton Dr. Arcadia, CA 91007	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure staff followed the facility's enhanced barrier precautions (EBP- refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs-bacteria that have become resistant to certain antibiotics and these antibiotics can no longer be used to control or kill the bacteria] that employs targeted gown and glove use during high contact resident care activities) and standard precautions (a set of infection control practices used to prevent the spread of diseases), and perform handwashing/hand hygiene (cleansing your hands with soap and water or alcohol based hand sanitizers) in accordance with the facility's policy for four of 19 sampled residents (Residents 6, 18, 28 and 88) by failing to ensure:</p> <ol style="list-style-type: none"> <li>1. Staff doffed (remove) gloves and hand hygiene after peri-care (cleaning the genitals and anal area) for Resident 6.</li> <li>2. Staff doffed gloves and hand hygiene after emptying urinal for Resident 88.</li> <li>3. Staff performed hand hygiene after doffing gloves and before handling clean laundry.</li> <li>4. Resident 28, who had a left upper chest permacath (tunneled hemodialysis catheter, a flexible tube used for dialysis treatment that is inserted into the blood vessel in your neck or upper chest), had an EBP signage and personal protective equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. PPEs may include gloves, safety glasses and shoes, gowns, or coveralls) posted outside the room.</li> <li>5. Staff wear PPE and perform hand hygiene after touching Resident 28 to take the blood pressure (BP-the force of blood pushing against the walls of your arteries, measure in milliliters of mercury [mmHg]) and heart rate (HR-the number of times your heart beats in one minute. To measure, check your pulse by feeling for your heartbeats in your neck or wrist).</li> <li>6. Staff performed hand hygiene before and after touching Resident 18 to measure her HR and before preparing and after giving her medications.</li> </ol> <p>These deficient practices had the potential to spread infection among staff and residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 6's Admission Record, the Admission Record indicated resident was admitted on [DATE] with the following diagnoses of dysuria (pain and/or burning, stinging, or itching of the urethra during urination) and Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease causing difficulty in breathing)</li> </ol> <p>During a review of Resident 6's History and Physical (H&amp;P), dated 3/7/2024, the H&amp;P indicated resident has the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. MDS also indicated resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and personal hygiene. MDS indicated resident was always continent with bowel and bladder.</p> <p>During an observation on 1/15/2025 at 3:10 PM, Certified Nursing Assistant 4 (CNA 4) was observed providing peri-care to Resident 6. CNA 4 was also observed not changing the gloves and not perform hand hygiene after caring for the resident, and with the same gloves CNA 4 touched Resident 6 and her wheelchair.</p> <p>During an interview on 1/15/2025 at 3:20 PM, CNA 4 stated she should have removed her gloves, performed hand hygiene and changed gloves prior to touching Resident 6 and her wheelchair. CNA 4 also stated it can spread infection.</p> <p>During an observation on 1/16/2025 at 11 AM, CNA 5 was observed providing peri-care to Resident 6. CNA 6 was observed not changing gloves and not perform hand hygiene after caring for the resident. CAN 6 used the same gloves when touching Resident 6, resident's wheelchair, and the sink.</p> <p>During an interview on 1/16/2025 at 11:20 AM, CNA 5 stated she stated she should have removed her gloves, performed hand hygiene and changed gloves prior to touching Resident 6, her wheelchair, and the sink. CNA 5 also stated that is infection control and can spread infection.</p> <p>During an interview on 1/16/2025 at 11:42 AM, Infection Preventionist Nurse (IPN) stated the CNAs should have doff the soiled gloves, perform hand hygiene and don (put on) new gloves after peri-care was provided to prevent the spread of infection.</p> <p>2. During a review of Resident 88 Admission Record indicated resident was admitted on [DATE] with the following diagnoses of unspecified fracture of the left fibula (calf bone), dislocation of the left ankle joint, gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints) and heart failure (heart muscle doesn't pump enough blood to the body).</p> <p>During a review of Resident 88's H&amp;P, dated 12/26/2024, indicated resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 88's MDS, dated [DATE], indicated resident is independent in cognitive skills for daily decision making. MDS also indicated resident required substantial/maximal assistance with roll left and right, sit to lying, lying to sitting on side of bed and toilet transfer. Resident also is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with sit to stand and char/bed to chair transfer.</p> <p>During a concurrent observation and interview on 1/16/2025 at 2:05 PM, CNA 7 was observed emptying a urinal. CNA 7 was also observed using the same gloves used to empty the resident's urinal, open Resident 88's sliding door and touch Resident 88's personal belonging. CNA 7 stated she should have doffed her gloves and performed hand hygiene after emptying the urinal to prevent the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/16/2025 at 3 PM, IPN stated CNA 7 should have taken off her gloves and performed hand hygiene after emptying the urinal and before touching anything else to prevent the spread of infection.</p> <p>3. During a concurrent observation and interview on 1/17/2025 at 10 AM, with IPN on the side, Laundry Staff (LS) was observed putting dirty clothes in the washing machine. LS then doffed off personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment) without performing hand hygiene. LS then continue taking out clean laundry from the washing machine, putting the clean laundry in the dryer and folding clean linen after handling soiled linen. IPN stated LS should have performed hand hygiene after doffing the PPE and before taking the clean laundry from the washing machine and prior to folding clean laundry.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Departmental (Environmental Services - Laundry and Linen, revised 1/2014, indicated wash hands after handling soiled linen and before handling clean linen. P&amp;P also indicated to consider all soiled linen to be potentially infectious and handle with standard precautions. P&amp;P also indicated employees sorting or washing linen must wear a gown and gloves.</p> <p>During a review of the facility's P&amp;P titled, Personal Protective Equipment - Gloves, revised 9/2010, indicated to use gloves when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin. P&amp;P also indicated wash hands after removing gloves. Gloves do not replace handwashing.</p> <p>During a review of the facility's P&amp;P titled, Handwashing/Hand Hygiene, revised 10/2023, indicated hand hygiene is done immediately after glove removal, after contact with blood, body fluids, or contaminated surfaces and before moving from work on a soiled body site to a clean body site on the same resident. P&amp;P also indicated the use of gloves does not replace hand washing/hand hygiene.</p> <p>49537</p> <p>4. During a review of Resident 28's Admission Record, the Admission Record indicated the facility initially admitted the resident on 7/16/2024 and was readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (ESRD-irreversible kidney failure) requiring hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic diastolic congestive heart failure (a chronic condition that occurs when the left ventricle of the heart becomes stiff and cannot relax normally. This prevents the heart from filling with enough blood between beats), and acute on chronic respiratory failure (respiratory failure is a condition where there is not enough oxygen [O2-a colorless, odorless gas essential for life, present in the air we breathe] or too much carbon dioxide [CO2-a colorless, odorless gas produced by burning carbon and organic compounds and by respiration]. It can happen all at once [acute] or come on over time [chronic]) hypoxia (low levels of oxygen in your body tissues).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 28's MDS, dated [DATE], the MDS indicated the resident had moderate impairment with cognitive skills for daily decision making. The MDS also indicated Resident 28 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and oral hygiene. The MDS also indicated Resident 28 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with personal hygiene. The MDS also indicated the resident required substantial/maximal assistance with showering/bathing self, upper and lower body dressing and was dependent with toileting hygiene and putting on/taking off footwear.</p> <p>During a concurrent observation and interview on 1/16/2025 at 8:06 AM, outside Resident 28's room, there was no EBP signage and PPE cart outside his room. Licensed Vocational Nurse 3 (LVN 3) stated Resident 28 had a left upper chest permacath. LVN 3 was observed taking Resident 28's blood pressure and HR without wearing gloves and gown. After taking resident's BP and HR, LVN 3 was observed not performing hand hygiene (cleansing your hands with soap and water or alcohol-based hand sanitizers) and proceeded with preparing Resident 28's medications and administering them.</p> <p>During a concurrent interview and record review on 1/16/2025 at 9:30 AM, with LVN 3, the Order Summary was reviewed. LVN 3 stated, there was no active order for EBP in the and there was no EBP signage and PPE cart or posted outside resident's room. LVN 3 also stated he did not remember that Resident 28 was supposed to be on EBP and did not know what precautions resident was supposed to be on when they have central lines or wounds. LVN 3 verified he did not perform hand hygiene after taking Resident 28's BP and HR and before and after preparing his medications and giving them to the resident. LVN 3 stated it was important to perform hand hygiene to prevent the spread of microorganisms to other residents and staff.</p> <p>During a concurrent interview and record review on 1/17/2025 at 12:47 PM with the IPN, the P&amp;P titled End-Stage Renal Disease, Care of a Resident with, revised September 2010 and Enhanced Barrier Precautions, revised April 2024, were reviewed. The IPN stated that EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The IPN further stated that Resident 28 was not on EBP and there was no order in the electronic medical records. The IPN stated there was no EBP signage and PPE cart outside Resident 28's room yesterday. IPN stated she had missed the permacath status for Resident 28 during her review of the EBP residents list. IPN stated it was important to follow EBP to prevent the spread of MDROs among the residents and staff.</p> <p>During an interview on 1/17/2025 at 1:30 PM with the Director of Nursing (DON), the DON stated residents on hemodialysis with central lines should be on EBP. The IPN did not have Resident 28 on her EBP list and that was why there was no EBP signage and PPE cart or posted outside his room. The DON stated performing hand hygiene before and after touching a resident was important to prevent the spread of microorganisms to other residents and staff that could cause infections.</p> <p>5. During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted the resident on 4/7/2019 with diagnoses that included but not limited to atrial fibrillation (an irregular heartbeat that occurs when the upper chambers of the heart quiver instead of beating effectively), DM, chronic diastolic congestive heart failure, dermatitis (a general term for skin inflammation that can cause a rash, itching, or other skin lesions), and dysuria (a symptom that describes pain or discomfort while urinating).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated the resident had intact cognitive skills for daily decision making. The MDS indicated the resident required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating. The MDS also indicated resident required supervision or touching assistance with oral hygiene, required partial/moderate assistance with upper body dressing, required substantial/maximal assistance with toileting and personal hygiene, showering/bathing self and lower body dressing and was dependent with putting on/taking off footwear.</p> <p>During a review of Resident 18's Medication Administration Record (MAR-the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional) for January 2025, the MAR indicated amiodarone hydrochloride 200 milligrams (mg-a unit of measurement if mass in the metric system equal to a thousandth of a gram), give one tablet by mouth one time a day for atrial fibrillation. Hold if HR is below 60 beats per minute.</p> <p>During an observation on 1/16/2025 at 9:05 AM in Resident 18's room, LVN 3 was observed not performing hand hygiene before and after manually checking resident's left radial (wrist area) pulse and also before touching the medication cart to prepare Resident 18's medication.</p> <p>During an interview on 1/16/2025 at 9:35 AM with LVN 3, LVN 3 stated and verified that he did not perform hand hygiene before and after touching Resident 18's left wrist to count her HR. LVN 3 stated and verified that he did not perform hand hygiene before preparing and administering Resident 18's medications.</p> <p>During an interview on 1/17/2025 at 1:30 PM with the DON, the DON stated performing hand hygiene before and after touching a resident was important to prevent the spread of microorganisms to other residents and staff that could cause infections.</p> <p>During a review of the facility's P&amp;P titled, Enhanced Barrier Precaution, revised April 2024, the P&amp;P indicated:</p> <ol style="list-style-type: none"> <li>1. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</li> <li>2. PPE supplies will be made available near or outside of the resident rooms, placement is at the discretion of the facility.</li> </ol> <p>During a review of the facility's P&amp;P titled, Standard Precautions, revised September 2022, the P&amp;P indicated standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. It also indicated standard precautions include the following practices:</p> <ol style="list-style-type: none"> <li>1. Hand hygiene-refers to handwashing with soap or the use of alcohol-based hand rub (ABHR), which does not require access to water.</li> <li>2. Hand hygiene is performed with ABHR or soap and water before and after contact with the resident and after contact with items in the resident's room.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Handwashing/Hand Hygiene, revised October 2023, the P&amp;P indicated the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The P&amp;P further indicated that hand hygiene is indicated immediately before touching a resident and after touching a resident.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45099</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within the resident's reach (arm's length) for one (1) of 19 sampled residents (Residents 15) as indicated on the facility's call light policy.</p> <p>This deficient practice had the potential for Residents 15 not being able to call the facility's staff for help or assistance especially during an emergency.</p> <p>Findings:</p> <p>During a review of Resident 15's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included cerebral infarction (a medical condition that occurs when brain tissue dies due to a lack of blood flow and oxygen), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and history of falling.</p> <p>During a review of Resident 15's Care Plan initiated on 7/25/2023, the Care Plan indicated a focus on Resident 15's alteration in physical functioning and an approach plan to ensure call light was within reach.</p> <p>During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 15 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 15 was dependent (helper does all the effort) with shower, lower body dressing and putting on/taking off footwear and required substantial assistance (helper does more than half the effort) with toileting and personal hygiene, and upper body dressing. The MDS further indicated Resident 15 required supervision (helper provides verbal cues) with oral hygiene and setup assistance (helper sets up; resident completes activity) with eating.</p> <p>During an observation on 1/14/2025 at 3:34 PM, Resident 15 was in bed sleeping with his call light on the left side of the floor.</p> <p>During an interview on 1/15/2025 at 3:49 PM, Certified Nursing Assistant 1 (CNA 1) stated call lights should be within residents reach so the residents could call the staff when they needed help.</p> <p>During an interview on 1/15/2025 at 4:09 PM, Registered Nurse 1 (RN 1) stated the call lights should be within residents reach in case they needed assistance, and the residents could call the staff during emergencies.</p> <p>During an interview on 1/17/2025 at 9:18 AM, the Director of Nursing (DON) stated the residents call lights should be within the residents reach in case the residents needed to call for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure titled, Call Light, revised January 2024, indicated that the residents are provided with a means to call for assistance through a communication system that directly calls a staff member or a centralized workstation. The policy also indicated that the residents call light shall be within reach.</p>