STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056144	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Park Nursing Center	6425 Miles Avenue Huntington Park, CA 90255

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of four sampled residents ' (Resident 2) pain medication was reordered from the pharmacy at least seven (7) days in advance, as indicated in the facility ' s policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy. This deficient practice placed Resident 2 without the pain medicine available when needed resulting in the resident ' s discomfort and risk for severe pain. This deficient practice had the potential to affect in maintaining the resident ' s highest practicable physical, mental, and psychosocial well-being. Findings: During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with a diagnoses including chronic pain (persistent pain that lasts longer than 3 to 6 months, extending beyond the typical healing time for an injury or illness), pressure ulcer (wound) of left buttocks, stage 4 (a severe, deep wound extending into muscle, tendon, or bone, with a high risk of infection), and acute osteomyelitis (acute osteomyelitis.) During a review of Resident 2 ' s History and Physical (H&P) dated 5/27/2025, the H&P indicated Resident 2 had the mental capacity to understand and make medical decisions. During a review of Residents 2 ' s Minimum Data Set (MDS – a resident assessment tool), dated 5/30/2025, the MDS indicated Resident 2 had intact cognition. The MDS indicated Resident 2 required substantial/maximal assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 2 ' s Physician ' s orders dated 5/25/2025, the physician ' s order indicated Hydrocodone-Acetaminophen (Norco, a controlled [abused/ dangerous] pain medication) oral tablet 10-325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (4-10) (pain scale). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s progress notes dated 6/6/2025 timed 10:04 a.m., the progress notes indicated the authorization form for Norco tablet 5-325 mg was faxed to the primary physician ' s office (MD 1) office. The progress notes indicated Licensed Vocational Nurses (LVN 4) spoke to receptionist and was informed that the authorization form needing the physician ' s signature had been received and will be sent to MD 1 for signature. The progress notes indicated LVN 4 was informed that MD 1 will be back Monday, 6/9/2025 and there was no Physician Assistant (PA) available. The progress notes indicated LVN 4 paged MD 1 regarding the authorization form that needed to be signed. At 4:16 p.m., the progress notes indicated the refill authorization form for Hydrocodone-Acetaminophen oral tablet 10-325 mg from MD 1 had been received and was faxed to the pharmacy. At 6:20 p.m., the progress notesindicated the pharmacy received the faxed refill authorization form and indicated the Hydrocodone-Acetaminophen oral tablet 10-325 mg. medication will be delivered the night (time not specified) of 6/6/2025. During a review of Resident 2 ' s Medication Administration Record (MAR) for 6/2025, the MAR indicated Resident 2 did not receive Hydrocodone-Acetaminophen on 6/6/2025. During an interview on 6/10/2025 at 9:08 a.m. with Resident 2, in Resident 2 ' s room, Resident 2 stated he had pain in the back (unspecified) and in the buttocks wound. Resident 2 stated she asked LVN 3 on 6/6/2025 (time not specified) for herpain medication but was told by LVN 3 that she has no Norco medicine available and needs to be reordered from the pharmacy. Resident 2 stated LVN 3 told her the Norco will be delivered Monday (6/9/2025). Resident 2 stated she needed the Norcobecause of her back and wound pain. Resident 2 stated it is difficult to be in pain. Resident 2 stated later that afternoon, she asked LVN 3 if the medication was available and was told by LVN 3 they are waiting for the pharmacy to deliver the medications. Resident 2 stated shedid not receive Norco until the evening (time unspecified). During an interview on 6/10/2025 at 12:40 p.m. with LVN 3, LVN 3 stated Resident 2 ' s Norco was not available and was reordered 6/6/2025. LVN 3 stated Resident 2 did not get her Norco because we were waiting for the medications from the pharmacy. LVN 3 stated it was important for Resident 2 ' s pain medications to be available so that the resident will not suffer of pain. LVN 3 stated being in pain can affect Resident 2 ' s mental and physical well-being. LVN 3 stated it was not acceptable for Resident 2 to wait for medications. LVN statedmedication refills should be ordered timely. During a concurrent interview and record review on 6/10/2025 at 1:48 p.m. with the Registered Nurses (RN) 1, the RN 1 stated medications are ideally ordered 5 days prior to the medications running out. The RN 1 stated the pharmacy would refill controlled medications, after an authorization was obtained from the doctor. The RN 1 stated the authorization is then faxed to the pharmacy, and the medications will be delivered to the facility. The RN 1 stated if Resident 2 was on pain, we should have obtained an authorization from pharmacy and the doctor for a one-time dose and took the medication from the pyxis (medication dispensing and supplies are available when needed). The RN 1 stated if Resident 2 ' s pain was not managed in a timely manner, Resident 2 could get anxious, be uncomfortable and can develop clinical issues such as tachycardia (rapid heartbeat) or hypertension (high blood pressure.) The RN 1 reviewed Resident 2 ' s MAR on 6/6/2025 and stated no Norco medication was administrated that day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2025 at 2:52 p.m. with the Director of Nursing (DON), the DON stated controlledsubstances are orderedwhen the blue line (a marker) appeared in the medication ' s bubble pack. The DON stated if Resident 2 complained of pain and medication was not available, the nurses could have calledthe doctor and if it was available, the Norco could have been removed from the pyxis. The DON stated our responsibility was to provide Resident 2 the best quality of care. The DON stated being in pain can affect Resident 2 ' s functional mobility, Activities of Daily Living, and could result to tachycardia, hypertension and abnormal vital signs. During a review of the facility ' s P&P titled, Medication Ordering and Receiving from Pharmacy, dated 2/2010, the P&P indicated medications should be reordered three to four days in advance of need, to assure an adequate supply is on hand. The P&P indicated, when reordering medications that required special processing (such as controlledsubstance), the order should be at least seven (7) days in advance of need.