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	05/04/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 4), who had a sacrococcygeal (tailbone) wound, received the treatment and care in accordance with professional standards of practice and the resident's comprehensive person-centered care plan by failing to ensure the topical medication ordered by the physician was administered by a licensed nursing personnel and was not left at the bedside, unattended. This failure had the potential for Resident 4's wound to worsen and placed other residents at risk for accidental ingestion, leading to complications and hospitalization. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included pressure ulcer of sacral region unstageable (full-thickness wound obscured by slough or eschar, making the true depth and tissue involvement impossible to assess until debridement occurs), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN-high blood pressure) During a review of Resident's 4 care plan titled Pressure Ulcer indeterminate related to sacral deep tissue injury to sacrococcygeal, dated 4/10/2026, the interventions indicated provide wound care per treatment order. During a review of Residents 4's Minimum Data Set (MDS - a resident assessment tool) dated 4/13/2026, the MDS indicated Resident 4 had moderate cognitive impairment. The MDS indicated Resident 4 was partial to moderate assistance on staff with ADLs such as dressing, toilet use, transfer and mobility. Resident 4 was dependent on toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear.During a review of Resident's 4 physician's orders dated 4/28/2026, the physician's order indicated to cleanse the sacrococcygeal area with NS (Normal Saline- a cleansing solution), pat dry, apply calmoseptine every day shift for resolved pressure ulcer (PU), deep tissue injury (DTI, purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) for 30 days. During a concurrent observation and interview on 5/4/2026 at 10:30 a.m. with Resident 4 in the resident's room, Resident 4 was observed sitting at the bedside and a medicine cup that contained a thick pink cream, was noted on top of the bedside table. When asked what was inside the cup, Resident 4 stated it was a cream she needed to apply to her sacral (tailbone) skin sore (wound). Resident 4 stated that a nurse (unidentified name) had given her the cream one week ago and instructed her to apply it daily. Resident 4 stated, I always keep the cup with the cream on my bedside table uncovered. During a concurrent observation and interview on 5/4/2026 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 entered Resident 4's room and observed a medicine cup containing a topical cream at the bedside. LVN 1 stated the cream appeared to be Calmoseptine, a skin protectant used for the sacral area. LVN 1 stated it was not acceptable to leave the medication with the resident and instruct the resident to self^apply or to leave the cup with topical cream unattended at the bedside. Another resident might mistake it for food and eat it. During an interview on 5/4/2026 at 2:01 p.m. with LVN 3, LVN 3 stated that licensed nurses must follow physician orders and were responsible to apply topical creams to the resident. LVN 3 stated that even when a resident is capable of self^administration, the resident must be supervised during administration of the medication. During a review of facility'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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedures (P&P) titled, Medication Administration-General Guidelines, dated 1/2026, the P&P indicated that medications should be administered only by licensed nursing personnel authorized by state laws and regulations to administrate medications. The P&P indicated medications are administrated in accordance with written orders of the prescriber and the person who prepared the dose for administration is the person who administrates the dose.