

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2025
NAME OF PROVIDER OR SUPPLIER Huntington Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 Huntington Drive South Los Angeles, CA 90032	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the surgical face mask (a loose-fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment) of one of 4 staffs, was worn correctly while in a resident-care area, as indicated in the facility's policy and procedure (P&P) titled, Personal Protective Equipment-Using Face Masks. This failure had the potential to increase the spread of Coronavirus Disease 2019 ([COVID-19] highly contagious viral infection) virus to other residents, staff, and visitors in the facility, resulting in respiratory infections, hospitalizations and death. Findings: During a concurrent observation and interview on 8/18/2025 at 10:30 a.m. with Restorative Nurse Assistant (RNA 1) in Resident 2's room, RNA 1 was observed wearing surgical face mask below her nose with both nares (nasal openings) exposed. RNA 1 acknowledged the surgical face mask was applied incorrectly. RNA 1 stated putting on a surgical face mask incorrectly increased the potential to spread the COVID-19 virus to the residents. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it), cellulitis (a bacterial infection of your skin and the tissue beneath your skin) and hypertension (high blood pressure). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 5/19/2025, the MDS indicated Resident 3 had clear speech, was able to express needs and wants and understands. The MDs indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting and personal hygiene. During an interview on 8/18/2025 at 10:45 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated all staff should wear their surgical face mask correctly when inside the facility by covering the nose and mouth. The IPN stated not wearing the surgical face mask correctly had the potential to increase the risk in spreading COVID-19 virus and other germs to the other residents, staff and visitors in the facility. During a review of the facility's P&P titled Personal Protective Equipment-Using Face Masks, dated 9/2010, the P&P indicated staff should ensure face mask covers the nose and mouth while performing treatment or services.</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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