STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview, and record review the facility failed to ensure two of two sampled residents (Resident 3 and Resident 5) were free from physical abuse from Resident 4 by failing to: 1. Protect Resident 3, who required moderate assistance with activities of daily living (ADLs), from Resident 4. On 3/22/25, Resident 4 threw water at Resident 3 and hit Resident 3's left elbow with a metal bar which was removed from the arm rest of Resident 4 ' s wheelchair. Resident 3 experienced bruising and redness on their elbow, and stated that they felt anxious, angry, and upset after being hit by Resident 4. 2. Protect Resident 5, who was legally blind, from Resident 4, after facility staff moved Resident 4 to Resident 5 ' s room following the physical altercation between Residents 3 and 4 on 3/22/25. Five days after moving Resident 4 into Resident 5 ' s room, Resident 4 hit Resident 5 on the left side of the face with a radio. Resident 5 sustained a forehead laceration (a cut or tear in the skin resulting from tearing or blunt force) that measured 2 cm (centimeters) by 0.5 cm, as well as redness. Resident 5 stated that he felt upset following the incident, as he was blind, and could not see anything. Findings: 1. A review of Resident 3 ' s Admission Record documented that Resident 3 was admitted to the facility on [DATE] with a diagnoses including heart failure, abnormalities of gait (walking) and mobility, and dysphagia (difficulty swallowing). A review of Resident 3 ' s History and Physical (H&P) dated 3/15/25, documented that Resident 3 had the capacity to understand and make decisions. A review of Resident 3 ' s Minimum Data Set (MDS- a resident assessment tool) dated 3/17/25, documented that Resident 3 required set up or clean up assistance with eating. Resident 3 required supervision (helper provided cues) with oral hygiene, upper body dressing and personal hygiene. The MDS documented that Resident 3 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off of footwear. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Care Plan for Resident was allegedly hit by another patient, initiated on 3/22/25, the Care Plan indicated to monitor resident for 72 hours and for a wellness check by social services for 72 hours. A review of Resident 3 ' s Situation Background, Action and Response (SBAR) dated 3/22/25 indicated Resident 3 was allegedly hit by Resident 4 on the left elbow with Resident 4 ' s wheelchair armrest. A review of Resident 3 ' s Statement for Abuse/ Neglect Allegation, dated 3/22/25, indicated Resident 3 was hit on the left elbow by Resident 4 with Resident 4 ' s wheelchair arm rest that was removed by Resident 4. The Statement indicated that an assessment was conducted on Resident 3 with no signs of distress, pain, or injuries. The Statement indicated that facility staff immediately separated Resident 3 and Resident 4. A review of Resident 3 ' s Initial Psychiatric Evaluation, dated,3/25/25 indicated Resident 3 was involved in a recent altercation with Resident 4 on Saturday (3/22/25). The Evaluation indicated Resident 3 stated that crazy guy [Resident 4] said he ' s going to kill me and my family. I told him to turn his TV down and he threw water at me. Resident 4 grabbed the armrest and started to hit me. The Evaluation indicated Resident 3 was reported by staff to show anxiety. 2. A review of Resident 4 ' s Admission Record indicated that Resident 4 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of motor and sensory function in the lower half of the body), muscle weakness, and lack of coordination. A review of Resident 4 ' s History and Physical (H&P), dated 3/14/25, indicated the resident had the capacity to understand and make decisions. A review of Resident 4 ' s Minimum Data Set (MDS- a resident assessment tool), dated 3/18/25, indicated the resident had intact cognition (the ability to process thoughts). The MDS also indicated Resident 4 required setup assistance (helper assists only prior to or following the activity. Resident completes activity.) on self-care activities such as eating, upper body dressing, and personal hygiene. The MDS also indicated the resident required set up assistance for mobility activities such as rolling left and right and moving from sitting position to lying in bed. The MDS also indicated the resident was independent (Resident completes the activity by themself with no assistance from a helper) for mobility activities such as the ability to wheel himself while seated on a manual wheelchair. A review of Resident 4 ' s Care Plan for allegedly hitting another patient, initiated on 3/22/25, indicated Resident 4 was at risk for emotional distress related to the recent incident with another resident. The Care Plan indicated a goal for Resident 4 to not allegedly hit another resident. The Care Plan indicated interventions to transfer to a different room to station 4 right away for safety and to monitor the resident for 72 hours. The care plan lacked interventions for what to do. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/22/25, for Resident 4 to be referred for a psychiatric consult. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4 ' s Nurses Progress Note, dated 3/22/25 at 9:42 AM, indicated Resident 3 informed licensed vocational nurse (LVN) 6 that Resident 4 hit Resident 3 on the left elbow with the arm rest of Resident 4 ' s wheelchair. The Note indicated Resident 4 was moved to another room. The Note indicated for frequent visual monitoring, psychiatric consult and for social services to have a meeting with Resident 4. A review of Resident 4 ' s Statement for Abuse/ Neglect Allegation, dated 3/22/25, indicated Resident 3 was hit on the left elbow by Resident 4 with Resident 4 ' s wheelchair arm rest that was removed by Resident 4. The Statement indicated that an assessment was conducted on Resident 3 with no signs of distress pain, and injuries. The Statement indicated Resident 3, and Resident 4 were immediately separated. A review of Resident 4 ' s Care Plan for Going to other patients ' room, initiated on 3/24/25, indicated interventions to re-direct Resident 4. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/24/25, for a psychiatric consult for behavior and going to other residents ' room. A review for Resident 4 ' s Care Plan for Resident exhibits or has the potential to exhibit physical behaviors relate to: History of harm to others: assaultive actions toward other residents, initiated on 3/25/25, indicated a goal for Resident 4 to not harm others. The Care Plan interventions indicated for social service visits to provide support, and to evaluate the nature and circumstances of the physical behavior with Resident 4. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/25/25 for a psychiatric consult. A review of Resident 4 ' s Psychiatrist Initial Evaluation, dated 3/25/25, indicated Resident 4 was assessed to be agitated, aggressive, suspicious, and irritable. The notes indicated that during the interview, Resident 4 was angry and very uncooperative with the interview process. Further review of the notes indicated facility staff reports that the [resident] displayed some level of anxiety in recent days such as agitation and irritability. The Note indicated recommendation for staff to contact GACH for a 5150 (a 72-hour involuntary psychiatric hold) evaluation. The notes added that the resident was also exhibiting increased behavioral issues, such as aggression or mood swings. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/25/25, for Resident 4 to be assessed by the Psychiatric Emergency Team (PET -mobile teams operated by psychiatric hospitals) team and to be transferred to the General Acute Care Hospital (GACH). A review of Resident 4 ' s Nurses Progress Note, dated 3/25/25 at 6:29 PM, indicated the facility attempted to call the PET team. Once the facility contacted the PET Team, Resident 4 could not be assessed since the PET team could only assess Resident 4 if Resident 4 was transferred to where the PET Team was. A review of Resident 4 ' s Nurses Progress Note, dated 3/25/25 at 10:58 PM, indicated Resident 4 was seen by the crisis management team (a group of skilled staff members who plan for and respond to major issues that could harm the company) and did not qualify for a 5150 hold. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4 ' s Progress Note for SBAR (situation, background, action, and response), dated 3/27/25 at 5:05 AM indicated at approximately 5:05 AM heard a noise Help, Help! The SBAR indicated LVN 7 went into Resident 4 and Resident 5 ' s room and saw Resident 4 in his wheelchair next to Resident 5. The SBAR indicated Resident 5 was bleeding and had a skin tear on the left side of the face and redness to the left side of the forehead. The SBAR indicated Resident 5 stated he hit me with radio. The SBAR indicated Resident 4 and 5 were separated and that the facility changed Resident 4s room. A review of Resident 4 ' s Care Plan for allegedly hit roommate in the head/face, initiated on 3/27/25, indicated at risk for emotional distress related to the recent incident with another resident. The Care Plan indicated to monitor Resident 4 ' s behaviors every shift, separate Resident 4 from other residents, remove triggers, and transfer Resident 4 to the hospital. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25, that Resident 4 may be evaluated by the PET team and transfer to the GACH for psychiatric hold. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for PET Team evaluation for a 5150 hold and for possible addition to GACH due to aggressive behavior. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for Resident 4 to be a 1:1 watch (constant, uninterrupted monitoring of a patient by a nurse or staff member to ensure their safety and prevent harm). A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for Ativan solution (treat anxiety disorders) 2 milligram per milliliter (mg/ml- a unit of measurement), inject 1 mg intramuscularly (IM- in the muscle) every 8 hours as needed for aggressive behavior. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for Ativan solution 2 milligram per milliliter (mg/ml- a unit of measurement), inject 2mg IM one time only for aggressive behavior for 1 day. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for Haldol Injection Solution (a medication that is used to control behavior) 5mg/ml inject 5 mg IM every 24 hours as needed for aggressive behavior. A review of Resident 4 ' s Order Summary Report indicated a physician order dated 3/27/25 for Haldol Injection Solution 5mg/ml, inject 5 mg IM one time only for aggressive behavior for 1 day. A review of Resident 4 ' s Nurses Progress Note, dated 3/27/25 at 12:32 PM indicated Resident 4 was transferred to the GACH via transport with all his belongings for a psychiatric evaluation. A review of Resident 4 ' s Nurse Progress Note, dated 3/27/25 at 5:20 PM, indicated Resident 4 was readmitted back to the facility and placed on a 1:1 watch. 3. A review of Resident 5 ' s Admission Record indicated the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses that included visual loss on both eyes, hearing loss on both ears, muscle weakness, aphasia (a disorder that affects a person ' s ability to communicate), altered mental status, and dementia (a progressive state of decline in mental abilities). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 5 ' s History and Physical (H&P), dated 9/19/24 indicated the resident has fluctuating capacity to understand and make decisions. A review of Resident 5 ' s Care Plan for exhibiting or having potential to demonstrate verbal behaviors related to history of verbal outbursts directed toward others (use of abusive language, pattern of challenging/confrontation verbal behavior and refusing care), initiated on 2/5/24, indicated the goal was for Resident 5 to verbale understanding of triggers. The Care Plan interventions indicated to evaluate the nature and circumstances of the verbal behavior with resident. A review of Resident 5 ' s Care Plan for Increase confusing, non-stop screaming and yelling without cause in Spanish, initiated 8/15/24 indicated interventions to inform the physician of the current situation and for further evaluation at the GACH. A review of Resident 5 ' s MDS, dated [DATE], indicated the resident has severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects) at the time of the assessment. The MDS indicated the resident has moderately impaired cognition. The MDS also indicated the resident requires substantial assistance (helper does more than half the effort) on self-care activities such as eating, oral hygiene, toileting. A review of Resident 5 ' s Care Plan for requiring bedside activities for social and sensory program (legally blind), revised on 3/10/25, indicated interventions that included Resident 5 enjoyed listening to music with radio at bedside, and for the TV to be on for stimulation. A review of Resident 5 ' s Order Summary Report, indicated a physician ' s order dated 3/27/25 to cleanse skin tear to left side of face with NS [normal saline, a water and salt solution used for cleaning wounds] pat dry, apply betadine solution [a cleaning solution] and cover with dry dressing daily x 14 days then [re-evaluate] one time a day for 14 days. A review of Resident 5 ' s Care Plan for Claimed of being hit by another resident in the face/head initiated on 3/27/25, indicated interventions to monitor for: vital signs (VS), emotional distress and pain. A review of Resident 5 ' s Care Plan for Redness to the left side of the forehead, indicated on 3/27/25, indicated to monitor for: VS every shift, pain and for an x-ray to the skull/face. A review of Resident 5 ' s Care Plan for Skin tear to the left side of the face, initiated on 3/27/25 indicated to monitor for pain and signs and symptoms of infection. A review of Resident 5 ' s CIC, dated 3/27/2025, timed at 5:05 AM, indicated Resident 5 was bleeding with skin tear from left side of the face and left forehead with redness. The CIC also indicated the skin tear was accompanied by significant pain or bleeding. The CIC indicated Resident 5 was legally blind and claimed Resident 4 hit Resident 5 with a radio. The CIC indicated left side of face tear measuring approximately 2 centimeters (cm- a unit of measurement) by 0.5cm and left side of the forehead with redness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 5 ' s Progress Note SBAR dated 3/27/25 at 5:05 AM indicated LVN 7 heard Resident 5 say Help, Help and when LVN 7 went into Resident 4 and 5 ' s room, Resident 4 was seated in his wheelchair next to Resident 4. Resident 5 had a skin tear and bleeding on the left side of the face and forehead with redness. The SBAR indicated Resident 5 stated he hit me with radio. During an interview on 3/25/25 at 9:38 AM, Resident 3 stated about two or three weeks ago, Resident 4 threw a cup of cold water at Resident 3 because Resident 3 told Resident 4 to lower the volume of his TV. Resident 3 stated Resident 4 ' s cup of water landed on Resident 3 ' s face and chest, and that Resident 3 reported the incident to a nurse, however there was nothing done about the incident, since Resident 4 still remained in the room with Resident 3. Resident 3 further stated that on 3/22/25, early in the morning, Resident 4 came up to Resident 3 ' s bed and hit Resident 3 with a metal bar, that was removed from the arm rest of Resident 4 ' s wheelchair. Resident 3 stated he covered his face with his arms and elbow, that was why Resident 3 had sustained bruising and pain to his arm. Resident 3 stated he was angry and upset that Resident 4 hit him just for asking Resident 4 to lower his TV volume. During a concurrent interview and record review on 3/26/25 at 1:51 PM with Registered Nurse Supervisor (RN 2), Resident 3 ' s and Resident 4 ' s incident statements titled, Abuse/Neglect Allegation, dated 3/22/2025 were reviewed. The Incident Statements indicated Resident 3 and Resident 4 ' s statements were identical, and RN 2 stated she copied and pasted Resident 3 ' s statement onto the documentation of Resident 4 since Resident 4 denied the altercation between him and Resident 3. RN 2 stated no other investigation was completed. During an interview on 3/26/25 at 2:59 PM, Certified Nursing Assistant (CNA) 3 stated she has observed Resident 4 had a behavior of yelling the word what and would start punching the air. CNA 3 stated on 3/23/25, when she was inside Resident 4 and Resident 5 ' s room, she observed Resident 4 wheel himself toward Resident 5 and approached Resident 5 aggressively. CNA 3 stated Resident 4 looked like he wanted to fight. CNA 3 stated she reported her observations to a Licensed Vocational Nurse (LVN), but CNA 3 stated she did not know if any actions were taken as a response to her report to the LVN. CNA 3 stated she could not recall the LVN that she reported Resident 4 ' s behavior toward Resident 5 on 3/23/25. During an interview on 3/27/25 at 2:16 PM, LVN 5 stated she has not received or notified of a report from any staff that Resident 4 was exhibiting aggressive behavior toward Resident 5. During an interview on 3/27/25 at 2:41 PM, Registered Nurse (RN) 4 stated she was the nurse that transferred Resident 4 into Resident 5 ' s room on 3/23/25. RN 4 stated she thought Resident 5 was an appropriate roommate for Resident 4 since Resident 5 seemed okay. RN 4 stated she did not know Resident 5 was blind in both eyes. During an interview on 3/25/25 at 9:38 AM, Resident 3 stated Resident 4 came up to Resident 3 ' s bed on 3/22/25, early in the morning and hit Resident 3 with a metal bar, which was Resident 4 ' s arm rest that he removed from his wheelchair. Resident 3 stated covering his face with his arms and that was why Resident 3 had bruising and pain to his arm. Resident 3 stated he was angry and upset that Resident 4 hit Resident 3 for no reason. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/27/25 at 5:45 PM inside Resident 5 ' s room, Resident 5 was observed lying in bed with a square bandage on the left cheek. Resident 5 stated he was upset about getting hit in the face. Resident 5 stated he did not want to talk about the incident because it was upsetting him. To the left of Resident 5 ' s bed is a bedside table, and a radio was on top, measuring approximately 11 inches (a unit of measuring length) and 8 inches in height, and 8 inches in depth. During an interview on 3/27/25 at 6:03 PM, CNA 4 stated whenever Resident 5 played music on his radio, she observed that Resident 4 would get agitated by the music. CNA 4 stated she expressed to RN 4 that Resident 4 should not be assigned to the room with Resident 5, since Resident 4 exhibits aggressive behavior and Resident 5 was blind and vulnerable. CNA 4 stated that RN 4 expressed that she was told by another nurse, which name she could not recall, to place Resident 4 into Resident 5 ' s room. During an interview on 3/28/25 at 11:11 AM, Resident 5 stated feeling angry and was upset about getting hit on the face by Resident 4 with his radio. Resident 5 stated he was blind, and he could not do anything about what happened. During another interview on 3/28/25 at 11:28 AM with RN 4, RN 4 stated when Resident 4 was transferred to Resident 5 ' s room, an assessment should be conducted, however RN 4 stated there was no criteria to assess roommates' compatibility. RN 4 stated the compatibility was determined based on the nurse's judgment. RN 4 stated since Resident 5 liked to have his TV or radio on, which caused noise, it was not safe to place Resident 4 into Resident 5 ' s room. During an interview on 3/28/25 at 11:32 AM, the Director of Nursing (DON) stated when a resident was transferred to another room, roommate compatibility should be assessed. The DON stated to assess for roommate compatibility, the licensed nurses must assess the resident's history and behaviors, to ensure roommate compatibility. During a concurrent interview and record review on 3/28/25 at 11:59 AM, the facility ' s policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, effective 2/23/21, was reviewed with the DON. The DON stated the P&P must be followed to prevent resident abuse. The DON stated CNA 3 should have reported the verbal abuse of Resident 4 towards Resident 5 on 3/23/24 to the Administrator. The DON stated if the verbal abuse was reported, it would have prevented the physical abuse that followed when [Resident 4] hit [Resident 5] with the radio. During an interview on 3/29/25 at 12:10 PM, the Administrator (ADM) stated acts of verbal abuse must be reported to her. The ADM stated when verbal abuse occurs between two residents, they must be separated immediately to prevent further abuse. The ADM stated if verbal abuse was not reported to her, interventions to prevent further abuse would not take place, such as separating the two residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s P&P titled, Abuse Prohibition and Procedure, effective 2/23/21, indicated that Employees are designated as mandated reporters and are obligated to immediately report any suspicion of a crime against a resident. The P&P indicated Verbal abuse is any use of oral, written, or gestured language that includes disparaging and derogatory terms to patients or their families, or within their hearing distance . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a [resident] . The P&P indicated actions to prevent abuse would include: (5.2) Identifying, correcting, and intervening in situations in which abuse was more likely to occur. The P&P indicated 6.1 Anyone who witnesses an incident of suspected abuse, is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. And If the suspected abuse is resident-to-resident, the resident who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. The P&P indicated 6.2.1 The [facility] will provide adequate supervision when the risk of resident-to-resident altercation is suspected and that [facility] is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. A review of the facility ' s P&P titled, Abuse Prevention Program, revised 12/16, indicated the administration would protect residents from abuse by anyone including, but not necessarily limited to: facility staff, other resident. The P&P also indicated the administration will develop and implement policies and procedures to aid [the] facility in preventing abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51618 Based on observation, interview and record review, the facility failed to thoroughly investigate, take appropriate corrective action/steps, by not obtaining statements from residents involved in a physical altercation, and maintain documentation of the facility's thorough investigation to prevent further abuse, for one of two sampled residents (Resident 3) in accordance with the facility's Policy and Procedure (P&P) on Abuse Prohibition Policy and Procedure. This deficient practice resulted in an incomplete investigation of physical abuse and had the potential to place other residents at risk for abuse. Cross referenced to F600 FINDINGS: 1. During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with a diagnoses of heart failure, abnormalities of gait (walking) and mobility, and dysphagia (difficulty swallowing). During a review of Resident 3's History and Physical (H&P) dated 3/15/25, the HPE indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 3/17/25, the MDS indicated Resident 3 required set up or clean up assistance with eating. Resident 3 required supervision (helper provided cues) with oral hygiene, upper body dressing and personal hygiene. The MDS initiated Resident 3 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, shower, lower body dressing and putting on/taking off of footwear. During a review of Resident 3's Situation Background, Action and Response (SBAR) dated 3/22/25, the SBAR indicated Resident 3 was allegedly hit by Resident 4 on the left elbow with Resident 4's wheelchair armrest. During a review of Resident 3's Statement for Abuse/ Neglect Allegation, dated 3/22/25, the Statement indicated Resident 3 was hit on the left elbow by Resident 4 with Resident 4's wheelchair arm rest that was removed by Resident 4. The Statement indicated that an assessment was conducted on Resident 3 with no signs of distress pain, and injuries. The Statement indicated Resident 3 and Resident 4 were immediately separated. During a review of Resident 3's Care Plan titled, Resident was allegedly hit by another patient, initiated on 3/22/25, the Care Plan indicated to monitor resident for 72 hours and for a wellness check by social services for 72 hours. (continued on next page)

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Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Initial Psychiatric Evaluation, dated 3/25/2025, the Evaluation indicated Resident 3 was Spanish speaking and required staff assistance for translation. The Evaluation indicated Resident 3 was involved in a recent altercation with Resident 4 on 3/22/2025. The Evaluation indicated Resident 3 stated that crazy guy [Resident 4] said he's going to kill me and my family. I told him to turn his TV down and he threw water at me. He grabbed the armrest and started to hit me. The Evaluation indicated Resident 3 was reported by staff to show mild anxiety. 2. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of motor and sensory function in the lower half of the body), muscle weakness, and lack of coordination. During a review of Resident 4's H&P, dated 3/14/25, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated the resident had intact cognition (the ability to process thoughts). The MDS also indicated Resident 4 required setup assistance (helper assists only prior to or following the activity. Resident completes activity.) on self-care activities such as eating, upper body dressing, and personal hygiene. The MDS indicated the resident required set up assistance for mobility activities such as rolling left and right and moving from sitting position to lying in bed. The MDS also indicated the resident was independent (resident completes the activity by themself with no assistance from a helper) for mobility activities such as the ability to wheel himself while seated on a manual wheelchair. During a review of Resident 4's Care Plan for allegedly hitting another patient, initiated on 3/22/25, the care plan indicated Resident 4 was at risk for emotional distress related to the recent incident with another resident. The Care Plan indicated a goal for Resident 4 to Not allegedly hit another resident. The Care Plan indicated interventions to transfer Resident 4 to a different room at Station 4 Right away for safety and to monitor the resident for 72 hours. During a review of Resident 4's Order Summary Report indicated a physician order dated 3/22/25, the Report indicated for Resident 4 to be referred for a psychiatric consult. During a review of Resident 4's Nurses Progress Note, dated 3/22/25 timed at 9:42 AM, the Note indicated Resident 3 informed Licensed Vocational Nurse (LVN) 6 that Resident 4 hit Resident 3 on the left elbow with the arm rest of Resident 4's wheelchair. The Note indicated Resident 4 was moved to another room. The Note indicated for frequent visual monitoring, psychiatric consult and for social services to have a meeting with Resident 4. During a review of Resident 4's Statement for Abuse/ Neglect Allegation, dated 3/22/25, the Statement indicated Resident 3 was hit on the left elbow by Resident 4 with Resident 4's wheelchair arm rest that was removed by Resident 4. The Statement indicated that an assessment was conducted on Resident 3 with no signs of distress pain, and injuries. The Statement indicated Resident 3, and Resident 4 were immediately separated. During a review of Resident 4's Care Plan for Going to other patients' room, initiated on 3/24/25, the care plan indicated interventions to re-direct Resident 4. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Order Summary Report, the report indicated a physician order dated 3/24/25, for a psychiatric consult for behavior and going to other residents' room. During a review of Resident 4's Psychiatrist Initial Evaluation, dated 3/25/25, the Evaluation indicated Resident 4 was assessed to be agitated, aggressive, suspicious, and irritable. The notes indicated that during the interview, Resident 4 was angry and very uncooperative with the interview process. Further review of the notes indicated facility staff reports that the [resident] displayed some level of anxiety in recent days such as agitation and irritability. The notes added that the resident was also exhibiting increased behavioral issues, such as aggression or mood swings. During an interview on 3/25/25 at 9:38 AM, Resident 3 stated about two or three weeks ago, Resident 4 threw a cup of cold water at Resident 3 because Resident 3 told Resident 4 to lower the volume of his TV. Resident 3 stated Resident 4's cup of water landed on Resident 3's face and chest, and that Resident 3 reported the incident to a nurse, however there was nothing done about the incident, since Resident 4 still remained in the room with Resident 3. Resident 3 further stated that on 3/22/25, early in the morning, Resident 4 came up to Resident 3's bed and hit Resident 3 with a metal bar, that was removed from the arm rest of Resident 4's wheelchair. Resident 3 stated Resident 4 swung the armrest at Resident 3, and the armrest hit Resident 3's left elbow/arm, since Resident 3 had lifted his left arm to shield himself. Resident 3 stated he covered his face with his arms and elbow, that was why Resident 3 had sustained bruising and pain to his arm. Resident 3 stated he was angry and upset that Resident 4 hit him just for asking Resident 4 to lower his TV volume. During an interview on 3/26/2025 at 1:31 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the alleged abuse incident occurred on 3/22/2025. LVN 5 stated Resident 3 reported the abuse to an unnamed CNA who then informed LVN 5 and Registered Nurse Supervisor (RN) 2. LVN 5 stated Resident 4 was immediately moved to a different room, and the administrator was notified. LVN 5 and RN 2 completed the progress note and Care Plan together. LVN 5 assessed Resident 3 and stated, he did not have any visible injuries. During an interview on 3/26/2025 at 1:49 PM with RN 2, RN 2 stated on 3/22/2025, RN 2 asked Resident 3 for a statement on what occurred. Resident 3 stated his left elbow was hit by Resident 4 who used one of the armrests from his wheelchair. RN 2 also went to Resident 4, who was moved to a new room, and requested a statement of what occurred. Resident 4 denied anything happened with Resident 3. RN 2 saw Resident 4's wheelchair near his bed and observed one of the armrests was already removed. RN 2 stated she did not replaced Resident 4's wheelchair or investigated further why Resident 4 picks up objects and used the objects to hit other residents in order to prevent abuse to other residents in the facility. During a concurrent interview and record review on 3/26/2025 at 1:51 PM with RN 2, Resident 3 and Resident 4's incident statements titled, Abuse/Neglect Allegation, dated 3/22/2025 were reviewed. RN 2 stated the Statement records indicated Resident 3 and Resident 4's statements on 3/22/2025 were the same. RN 2 stated she copied and pasted Resident 3's statement onto the documentation for Resident 4's statement since Resident 4 denied the altercation between him and Resident 3. RN 2 stated no other investigation, or reassessment was completed for Resident 3 and 4's physical altercation that occurred on 3/22/2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 12:28 PM with the Administrator (ADM), the ADM stated once the facility was made aware of any alleged abuse incident, the licensed staff should obtain statements from the residents involved and any other witnesses. The licensed staff should complete the state form reporting the abuse to the appropriate agencies and the skin body assessment. The ADM could not provide additional documents or evidence that indicated thorough investigation of Resident 3 and 4's physical altercation on 3/22/2025. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, dated 2/23/21, the P&P indicated the facility will protect patients from further harm during an investigation. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, dated 2/23/21, the P&P indicated, causative factors must be investigated within two hours of an allegation of abuse, and that the investigation will be thoroughly documented.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 42878 Based on interviews and record reviews, the facility failed to ensure that one of two sampled residents (Resident 1), who had a diagnosis of Diabetes Mellitus ([DM, a chronic disease where a person has high blood sugar levels because the body does not produce insulin [a hormone that regulates blood sugar levels in the body]) and history of hypoglycemia (a condition were blood sugar levels drop below normal), received treatment and services, in accordance with professional standards of practice, the care plan, and physician orders for the management of DM and hypoglycemia. The facility failed to: 1. Ensure Registered Nurse (RN) 2 reviewed Resident 1's General Acute Hospital Records (GACH 2) on [DATE], for all appropriate GACH 2 discharge orders and ensure readmission orders from GACH 2 and continuity of care for DM was verified with the facility's attending physician (MD 1) or the facility's Nurse Practitioner (NP 1), upon readmission back to the facility on [DATE]. 2. Ensure the facility's licensed staff (Registered Nurse [RN] 2 and Licensed Vocational Nurse [LVN] 3) reviewed Resident 1's medical history of DM and history of hypoglycemic episode, requiring transfer to GACH 2 on [DATE], and was previously receiving blood sugar (BS) monitoring (the process of regularly checking and measuring the levels of blood sugar), prior to readmission to the facility to ensure continuity of diabetic care and management, on [DATE] to [DATE]. 3. Ensure Resident 1's care plan for DM was implemented by monitoring Resident 1 for hypoglycemia and hyperglycemia (a condition in which a person's blood sugar level is higher than normal) while residing at the facility from [DATE] to [DATE] (5 days). 4. Inform or verify with MD 1 or NP 1 on [DATE] that Resident 1's GACH 2 Discharge Summary orders dated [DATE] for BS monitoring before meals and at bedtime, including a routine insulin injection (Insulin Glargine [a long acting insulin used to manage blood sugar levels]) at bedtime was not ordered upon the resident's readmission back to the facility on [DATE], to manage the resident's DM. Licensed Vocational Nurse (LVN) 3 failed to obtain an order from MD 1 or NP 1 prior to entering an order for 10 units of routine insulin injection to be administered at bedtime on [DATE], three days after the resident's readmission to the facility. Additionally, LVN 4 failed to check Resident 1's blood sugar before administering the newly entered order of routine insulin injection on [DATE] at bedtime to Resident 1, in accordance with Resident 1's care plan for DM and P&P on Physician Orders. 5. Ensure LVN 1 and LVN 2 performed adequate assessment of Resident 1's condition on [DATE] and notified MD 1 or NP 1 of Resident 1's altered level of consciousness, blood sugar of 27 and low blood pressure (undocumented) on [DATE] and called 911 emergency services, in accordance with professional standards of practice and recommended guidelines for residents with hypoglycemia. As a result, Resident 1 had a change in condition in the morning of [DATE], as evidenced by altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment]), and hypoglycemia with a blood sugar of 27 (normal blood sugar levels are between 70 to 100). Resident 1 was transferred to GACH 3 via 911 emergency services (EMS - provides emergency medical care) on [DATE] and admitted to the Intensive Care Unit (ICU - provides the critical care and life support for acutely ill and injured patients). Resident 1 died at GACH 3 on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:51 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure to ensure a resident with a diagnosis of Diabetes Mellitus (DM) received treatment and services for diabetes. The team notified the Administrator (ADM) of an IJ situation on [DATE] at 4:51 PM, due to the facility's failure to ensure Resident 1 received the appropriate admission orders for diabetes care and management provided by a physician. On [DATE] at 1:48 PM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 1:52 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. After the IJ was removed, the surveyor verified that the facility's non-compliance remained at a lower scope and severity (refers to the seriousness of the harm to the residents) of isolated (refers to the deficiencies affecting a very limited number of resident/s), actual harm (means the resident have experienced a negative outcome or injury due to the non-compliance), that was not immediate jeopardy. The IJ Removal Plan dated [DATE], included the following: - On [DATE], the admitting licensed nurse was provided a one-to-one re-education and training by the vice president of education (VPE) on receiving diabetic treatment and services, in accordance with professional standards of practice, have care plan, and physician orders for the management of hypoglycemia. - Admitting licensed nurse will be provided re-education and training by the vice president of education on received diabetic treatment and services, in accordance with professional standards of practice, have care plan, and physician orders for the management of DM and hypoglycemia prior to her next scheduled work. - The interim director of nursing started [DATE] and was provided by the VPE with training on care plan for DM and review the resident's records to ensure the care plan is being followed, in accordance with the Director of Nursing's job description. - On [DATE], the Interdisciplinary Team (IDT - a group of healthcare professionals from various disciplines who collaborate to provide comprehensive patient care) was also provided education and training by the vice president of education regarding reviewing the residents plan of care upon admission/readmission, change of condition and as needed. - The Medical Director was informed by the administrator on [DATE] regarding the IJ findings for further corrective actions and recommendations. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diabetic residents (91) had their care plan reviewed. Eighteen (18) residents care plans were revised and 20 new care plans were initiated on [DATE] by the interim Director of Nursing or designees, to reflect blood glucose monitoring check order and current diabetic management protocol of hypoglycemia and hyperglycemia. - On [DATE], the interim Director of Nursing initiated education to licensed nursing staff on all shift on diabetic management with emphasis on the following:- Ensure diabetic residents upon admission/re-admission have blood sugar monitoring as ordered. - Ensure diabetic residents have parameters for low and high BS and has order to give when below/high BS parameters. - Ensure physicians are notified when resident's blood sugar falls below the parameters as specified by Physician. - Licensed Nurses that are newly hired, on vacation, on leave, part time, or on call and registry staff will be given inservice by the Interim DON or designee prior to the start of their shift or hired. - The facility's policies and procedures regarding Diabetic Management of residents was reviewed on [DATE]. - On [DATE], The Interim Director of Nursing or designee audited (1) new admission on [DATE] and current residents (91) with diagnosis of Diabetes for diabetic management and ensure appropriate interventions are in place and care planned. Facility created an audit tool for residents with diagnosis of Diabetes for diabetic management - New hires will receive education on Diabetic Management, and resident safety by the Interim Director of Nursing or designee. - Registry staff (staff personnel provided by a placement service on a temporary or on a day-to-day basis, in a facility) will be provided with accelerated orientation that includes checking of blood glucose levels and care plan initiation on residents upon admission/re-admission and as needed. - A Quality Assurance Performance Improvement (QAPI - a comprehensive, data-driven approach to continuously improve the quality of care and services in long-term care facilities) Performance Improvement Project (PIP) will be implemented to review and interpret all audit findings pertaining to the new admission and current residents with diabetes from Monday to Friday by the IDT during clinical meetings and RN Supervisor on weekends. - Monthly, the Interim DON and or designee will continue to review QAPI plan to address, monitor progress and address missed opportunities by conducting root cause analysis and continuous quality improvement with collaboration with attending physician's medical director, pharmacy consultant and company management clinical resource. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- New admissions/re-admissions will be reviewed from Mondays to Fridays, during clinical meeting by the IDT headed by the Interim DON and RN Supervisor on weekends to ensure that all admitted resident with Diabetes diagnosis, treatment and services with accordance with professional standard of practice which include diabetic management protocol for hypoglycemia and hyperglycemia, monitoring of blood glucose as ordered and care plan. - The RN Supervisor on weekends will review all admissions/re-admissions to ensure compliance with Diabetes treatment and services with accordance with professional standard of practice which include diabetic management protocol for hypoglycemia and hyperglycemia, monitoring of blood glucose as ordered and care plan. - The RN Supervisor during the shift will be notified by the Charge Nurse for any change of condition for coordination of care. Findings: During a review of Resident 1's Admission Record (AR), the AR documented that Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that inflames air sacs in one or both lungs, which may fill with fluid), sepsis (a serious condition in which the body responds improperly to an infection), respiratory failure (a serious condition that makes it difficult to breathe on your own), DM Type 2 , cerebral infarction (when a blood vessel in the brain is blocked, preventing blood and oxygen from reaching the brain tissue, leading to cell death), End Stage Renal Disease (ESRD- a condition in which the kidneys have lost most of their function and are no longer able to adequately filter waste products, excess fluids, and electrolytes from the blood). During a review of Resident 1's Physician Telephone Order (TO) dated [DATE] timed at 1:44 AM, the TO indicated, Insulin Lispro (a fast acting type of insulin) injection solution, inject as per insulin sliding scale (ISS - a chart of insulin dosages preordered for each blood sugar result): 2 units for BS of 150 - 199 [mg/dL], 4 units for BS of 200 - 249 [mg/dL], 6 units for BS of 250 - 299 [mg/dL], 8 units for BS of 300 - 349 [mg/dL], and 10 units for BS of 350 - 399 [mg/dL], Subcutaneously (SC-beneath the skin) at bedtime for Antidiabetics, before meals. During a review of Resident 1's Physician TO dated [DATE] timed at 2:01 AM, the TO indicated an order to admit Resident 1 under the care of MD 1. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 3:08 AM, the TO indicated Resident 1 was readmitted back from GACH 1. The Note indicated Resident 1 was alert and oriented. During a review of Resident 1's Medication Administration record (MAR), the MAR indicated a start date of [DATE] and discontinued (DC) date of [DATE]. The MAR showed the licensed nurses monitored Resident 1's blood sugar with Lispro ISS injection of 2 units for BS of 150 - 199, 4 units for BS of 200 - 249 [mg/dL], 6 units for BS of 250 - 299 [mg/dL], 8 units for BS of 300 - 349 [mg/dL], and 10 units for BS of 350 - 399 [mg/dL], Subcutaneously at bedtime for Antidiabetics, before meals from [DATE] to [DATE]. The MAR indicated the code HO which indicated Resident 1 was hospitalized from [DATE] to [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's MAR for February 2025, the MAR indicated Resident 1 was on insulin Glargine solution (long acting form of insulin), inject 10 units SC at bedtime [9 PM] for DM. The MAR indicated Resident 1 received one dose of Insulin Glargine 10 units routinely every 9 PM from [DATE] to [DATE]. The MAR indicated the code HO which indicated Resident 1 was hospitalized from [DATE] to [DATE]. During a review of Resident 1's MAR indicated a start date of [DATE] and DC date of [DATE], the MAR showed Resident 1 was on Metformin Hydrochloride (HCL) (a medicine taken by mouth to treat type 2 diabetes) oral tablet 1000 mg, one tablet by mouth two times a day for Antidiabetic. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 10:30 AM, the Note indicated Resident 1 was observed with altered level of consciousness (ALOC) staring at the ceiling, with cold clammy skin, BS was at 60 [mg/dL] with oxygen saturation (measures the percentage blood that is carrying oxygen - with normal levels between 95 to 100%) of 80%. The Note indicated the physician was notified and ordered the licensed nurse to transfer Resident 1 to the GACH via 911 EMS. The Note indicated EMS arrived on [DATE] at 10:45 AM and transferred Resident 1 to GACH 2 for ALOC. During a review of Resident 1's Physician TO dated [DATE] timed at 10:40 AM, the TO indicated an order to transfer the resident to GACH 2 for ALOC. During a review of Resident 1's GACH 2 records titled Discharge Summary dated [DATE], the DC Summary indicated Resident 1's discharge medications that included Insulin Glargine solution, inject 10 units subcutaneously (SC-beneath the skin) at bedtime and Insulin lispro, 0 units SC before meals and at bedtime. During a review of Resident 1's History and Physical Examination (HPE) from the facility, dated [DATE] and signed by Resident 1's attending physician (MD 1), the HPE indicated the resident had the capacity to understand and make decisions. The HPE indicated a handwritten Plan for Resident 1 that included blood sugar checks before meals and at bedtime with insulin sliding scale (ISS) and low dose insulin, Hemodialysis (a treatment to filter wastes and water from the blood) Mondays, Wednesdays and Fridays, fall precautions, and medication reconciliation. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 7:36 PM by RN 2, the Note indicated Resident 1 was readmitted back to the facility from GACH 2 due to altered mental status and metabolic acidosis (develops when too much acid is produced in the body). During a review of Resident 1's Physician TO dated [DATE] documented at 8:16 PM, the TO indicated an order to admit Resident 1 under the care of MD 1. During a review of Resident 1's Physician TO dated [DATE] documented at 8:21 PM, the TO indicated an order for: Insulin Lispro injection solution, inject as per sliding scale (ISS): 2 units for BS of 150 - 199, 4 units for BS of 200 - 249, 6 units for BS of 250 - 299, 8 units for BS of 300 - 349, and 10 units for BS of 350 - 399, Subcutaneously at bedtime for Antidiabetics, before meals. The order further indicated the BS monitoring was discontinued on [DATE] timed at 11:20 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's TO dated [DATE] documented at 1:43 AM was entered by RN 2 in Resident 1's electronic records. The TO indicated Resident 1 to be readmitted back to the facility. Further review of Resident 1's TO indicated no evidence of blood sugar monitoring ordered for Resident 1, after the blood sugar monitoring order had been discontinued on [DATE]. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 1:52 AM by RN 2, the Note indicated Resident 1's readmission orders and medications were reconciled and faxed to the facility pharmacy. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 7:49 PM by LVN 2, the Note indicated NP 1 came to visit Resident 1 at the facility and reviewed the resident's admission orders. During a review of Resident 1's MAR for February 2025 with a start date of [DATE], indicated Resident 1 was on Metformin HCL oral tablet 1000 mg, one tablet by mouth two times a day for DM2. The MAR indicated Resident 1 received one dose of Metformin by mouth on [DATE] (9 AM and on hemodialysis appointment at 5 PM), [DATE] (9 AM and 5 PM), [DATE] (9AM and 5 PM), [DATE] (9 AM and Resident 1 was HO at 5 PM). During a review of Resident 1's TO dated [DATE] (three days after Resident 1's readmission to the facility) documented at 10:44 AM and entered by LVN 3 in Resident 1's electronic records, the TO indicated to administer Insulin Glargine SC solution injection, 10 units subcutaneously at bedtime for Diabetes Mellitus. During a review of Resident 1's MAR for February 2025, the MAR indicated Resident 1 was started on Insulin Glargine solution, inject 10 units SC at bedtime [9 PM] for DM on [DATE]. The MAR indicated Resident 1 received one dose of Insulin Glargine 10 units on [DATE] at 9 PM. The MAR indicated the code HO (hospitalized) the next day on [DATE]. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 9:38 PM by LVN 4, the Notes indicated Insulin Glargine SC solution injection 10 units was administered to Resident 1 at bedtime on [DATE] (9 PM) for DM 2. The Note did not indicate evidence that Resident 1's BS was checked prior to the insulin administered by LVN 4. During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 11:35 AM by LVN 2, the Note indicated that the charge nurse (LVN 1) assigned to Resident 1 checked the resident's BS on [DATE], before lunch at 11:30 AM and the BS indicated 47. The Note indicated Glucose gel (an over the counter product taken by mouth to swallow and used to treat low blood sugar levels) and orange juice given. The Note indicated Resident 1 was Awake and able to swallow. The Note indicated the physician was notified and ordered to transfer the resident to GACH 3 for management of hypoglycemia. The Note indicated at the time of the evaluation Resident 1's BP at ,d+[DATE], pulse at 68, respiration at 20. During a review of Resident 1's Physician TO dated [DATE] documented at 1:48 PM by LVN 2, the TO indicated an order to transfer Resident 1 to GACH 3 due to low blood glucose (blood sugar) level. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Nurses Progress Notes dated [DATE] documented at 3:11 PM by LVN 2, the Note indicated the Emergency Medical Technician (EMT - provide out of hospital emergency medical care and transportation) transport arrived at 2 PM and refused to take Resident 1 to GACH 3 as ordered. The Note indicated that according to the EMT, the facility staff needed to Upgrade the call to 911. The Note indicated 911 paramedics/EMS was called by LVN 2. The Note indicated upon arrival of 911 (no time indicated) paramedics/EMS, Resident 1's BS was 37. During a review of Resident 1's Physician TO dated [DATE] documented at 3:22 PM by LVN 2, the TO indicated May transfer to GACH [3] via 911 for further evaluation of hypoglycemia. During a review of the EMTs Patient Care Report (ambulance transport) for Resident 1 with date of service [DATE], indicated the call type was Basic Life Support (BLS) Emergency (provides essential pre-hospital medical care and transportation for patients who are not in a critical condition, focusing on basic interventions and is staffed by trained EMTs]. The EMT Report indicated the EMTs time of arrival at Resident 1's room was at 2:15 PM. The EMT Report indicated the medical transport was Canceled on scene after the patient was evaluated timed at 2:40 PM. The EMT Report indicated Resident 1's vital signs timed at 2:17 PM indicated blood pressure (BP normal ranges between ,d+[DATE] to ,d+[DATE]) of ,d+[DATE], pulse was 77 weak normal range was 60 to 100), respiration was 14 (normal range was 12 to 20), oxygen saturation was 97%, and blood sugar level at 47. The EMT Report indicated the EMT requested LVN 1 to take another set of vital signs and BS and at 2:20 PM Resident 1's BP was at ,d+[DATE] with a BS of 27. During the same review of the EMT Report dated [DATE], the EMT Narrative indicated Resident 1 appeared to be altered (a change from a person's normal level of mental function) and disoriented. The EMT Narrative indicated LVN 1 stated that Resident 1 was Typically much more alert and responsive, tracking more appropriately. Patient (Resident 1) has had decreased level of alertness and altered mentation since approximately 12:30 (PM) today. The EMT report indicated At this time given severe hypoglycemia and hypotension (abnormally low blood pressure level) as well as patient's reported decreased mental status from baseline, EMTs agreed that patient needed to be upgraded to ALS (Advanced Life Support - refers to a medical service that provides advanced medical care to critically ill or injured patients during transport to a healthcare facility) call and patient was too unstable for BLS transport. The EMT Narrative indicated LVN 2 stated This was unnecessary and Resident 1 was stable enough to transfer to the acute hospital. The EMT Narrative indicated that EMT 1 spoke to NP 1 over the phone, in the presence of LVN 2 and reiterated Resident 1's instability and need for ALS transport while LVN 2 stated Resident 1 did not need 911 (ALS) transport. The EMT Narrative indicated LVN 2 was advised that LVN 1 had confirmed that Resident 1's decreased alertness was new onset for the past two hours and not Resident 1's baseline. (continued on next page)

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	056487	A. Building B. Wing	03/28/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of GACH 3 Emergency Department (ED) Reports dated [DATE] timed at 3:06 PM, the Report indicated Resident 1 arrived at the GACH 3 ED for Hypoglycemia. The Report included initial vital signs taken at [DATE] timed at 3:07 PM included temperature of 97.9, heart rate of 90, respirations of 16, BP of ,d+[DATE], oxygen saturation was 99%. The Report further indicated, Patient presents with hypotension, hypoglycemia . glucose was in the 20's . Given intravenous (IV - through the vein) Dextrose 50 and 250 milliliters (solution restores blood glucose levels in hypoglycemia) bolus of D5water (an IV solution used to provide hydration and calories, often used to treat dehydration [severe fluid loss in the body] or low blood sugar). Sugars improved to the 200's . [Resident 1] does not appear to be able to take anything by mouth at this time. The GACH 3 ED Report indicated Resident 1 was admitted to the GACH 3's ICU with diagnoses that included hypoglycemia, hypotension (abnormally low blood pressure), lactic acidosis (refers to lactic acid [produced when oxygen levels become low in cells within the areas of the body] build up in the bloodstream), and pneumonia (an infection of one or both of the lungs). During a review of GACH 3 Discharge Summaries Notes, Death Summary dated [DATE], the Death Summary indicated on [DATE] to [DATE], while waiting for hospice (a home providing care for the terminally ill patient) evaluation, Resident 1's code status was changed to a DNR (Do not Resuscitate - a legal document that instructs providers not to revive if a patient's breathing stops or if the patient's heart stops beating). The GACH 3 Death Summary indicated Resident 1 expired on [DATE] with final diagnoses that included chronic kidney (a condition where the kidneys are damaged and cannot filter blood as well as they should, leading to a gradual loss of kidney function over time) disease, hypoglycemia, hypotension, lactic acidosis, pneumonia, and septic shock (a condition in which the blood pressure fail, and the organs of the body fail to receive sufficient oxygen). During an interview on [DATE] at 12:12 PM with Resident 2, Resident 2 stated on [DATE], he was Resident 1's roommate and remembered EMT 1 coming into their room to take Resident 1 to the hospital but when EMT 1 saw Resident 1 was incoherent (talking in a confused/unclear way), EMT 1 told the nurse (LVN 2) I can't take him like this you have to call 911. Resident 2 stated LVN 2 and EMT 1 began to argue back and forth for a while. Resident 2 stated Resident 1 would often yell to call out for the nurses or say he wanted to go home but on that day ([DATE]) Resident 1 was just lying in bed just making like groaning noises. Resident 2 stated Resident 1 was not acting like his normal self. During an interview on [DATE] at 4:04 PM and record review of Resident 1's telephone readmission orders dated [DATE] and GACH 2 DC Summary and discharge medications dated [DATE] with the MDS (Minimum Data Set, a federally mandated assessment tool) Nurse, the MDS Nurse stated Resident 1's [DATE] readmission orders did not include an order for Blood Sugar monitoring or hypoglycemic protocol as well. The MDS Nurse stated the licensed nurses should have had both blood sugar monitoring on Resident 1's readmission because of DM diagnosis and past history of hypoglycemic episodes at the facility so that his BS levels could be monitored. The MDS Nurse indicated the admitting nurse (RN 2) should have clarified the missing admission orders by notifying MD 1 or NP 1. During a subsequent interview on [DATE] at 4:08 PM and record review of Resident 1's Care Plans for DM with the MDS nurse, the MDS Nurse stated Resident 1's Care plan for DM was not implemented by monitoring the resident for hypoglycemia and hyperglycemia while residing in the facility from [DATE] to [DATE], because Resident 1 did not have any order for blood sugar checks. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 12:59 PM with LVN 2, LVN 2 stated she was called by LVN 1 to Resident 1's room on [DATE] at around 11:30 AM because Resident 1's BS was 47. LVN 2 stated she rechecked Resident 1's BS but could not recall what the reading was and did not document. LVN 2 stated both LVN 1 and LVN 2 gave Resident 1 glucose gel and rechecked Resident 1's BS and read as 46. LVN 2 stated she thought Resident 1's BS was rechecked two more times and remained at 46. LVN 2 stated she called Resident 1's NP 1 and informed him of Resident 1's BS and that they had already administered glucose gel twice prior to calling him and Resident 1 was awake. LVN 2 stated she did not take Resident 1's vital signs because LVN 1 checked the vital signs but recalled the vital signs were normal. LVN 2 stated the NP 1 1 ordered a regular ambulance transport for Resident 1's transfer order to GACH 3. LVN 2 stated on [DATE] at around 2 PM, the ambulance transport arrived and the EMT's did not want to take Resident 1 to GACH 3 due to his low BS levels. LVN 2 stated she informed the EMTs their dispatch operator had said it was okay to transfer the resident because Resident 1 was awake and responsive but the EMT's refused. LVN 2 stated she called NP 1 and informed him the EMTs did not want to take Resident 1 because his BS was low, the EMT spoke to NP 1 and NP 1 decided to call 911. During a telephone interview on [DATE] at 1:50 PM with NP 1, NP 1 stated on [DATE] he remembered receiving a call from LVN 2 who informed him Resident 1 had a low blood sugar. NP 1 stated LVN 2 informed him Resident 1 was given glucose gels and was awake and alert. NP 1 stated he told LVN 2 it was okay to transfer Resident 1 to the hospital so he can be monitored for low blood sugar levels. NP 1 stated he ordered regular ambulance transport and not 911 emergency services based on the information he received from LVN 2, who informed him Resident 1 was alert and awake. NP 1 stated if he had been notified by LVN 2 that Resident 1 had ALOC with severely low BS, he would have ordered the licensed nurses to call 911 EMS. NP 1 stated Resident 1 should have had his BS checked routinely before meals and bedtime while in the facility. During an interview on [DATE] at 2:17 PM with LVN 1, LVN 1 stated that on [DATE], LVN 1 was Resident 1's assigned nurse. LVN 1 stated she remembered that around 8:30 AM to 9 AM Resident 1's CNA (CNA 1) approached her and asked to check on Resident 1 because he did not look good and did not look like himself. LVN 1 stated she went to Resident 1's bedside and immediately checked his vital signs. LVN 1 stated Resident 1's BP was ,d+[DATE] and the BS was 27. LVN 1 stated she thought the glucose machine was defective and went to get another glucose machine to recheck Resident 1's BS but received the same BS reading of 27. LVN 1 stated she did not document the BS of 27 and low BP because LVN 2 stated she would document Resident 1's change in condition. LVN 1 stated she asked for LVN 2s help. LVN 1 stated she told LVN 2 that Resident 1's BS was really low at 27 and that they should call 911 emergency services. LVN 1 stated LVN 2 gave Resident 1 three packets of glucose gel at the same time and observed LVN 2 directly squeezed the glucose gel into Resident 1's mouth because Resident 1 did not want to eat. LVN 1 stated LVN 2 prompted Resident 1 to swallow the glucose gel by tapping Resident 1's cheeks and throat so he would swallow the glucose gel. LVN 1 stated Resident 1 was just sitting and did not try help LVN 2 as she squeezed another glucose gel onto his mouth. LVN 1 stated Resident 1 appeared very weak. LVN 1 stated she told LVN 2 they should call 911 because Resident 1's BS levels were not going up but LVN 2 stated Resident 1's NP 1 wants Resident 1 to be transferred via regular ambulance transport to GACH 3. LVN 1 stated regular ambulance transport takes a long time to arrive as it is not for emergency situations. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the same interview on [DATE] at 2:17 PM, LVN 1 stated when the regular ambulance transport arrived and evaluated Resident 1, they stated they could not take Resident 1 because he was too unstable, and it was unsafe. LVN 1 stated EMT 1 informed us that Resident 1 required 911 emergency services. LVN 1 stated eventually LVN 2 called NP 1 and overheard the EMTs talking to NP 1 and informed NP 1 that either the facility calls 911 or the EMTs would call 911 to take Resident 1 to the GACH. LVN 1 stated she recalled LVN 2 getting angry and telling the EMTs to leave and then proceeded to get into an argument with the EMTs until the 911 paramedics arrived. LVN 1 stated she did not notify the facility's Registered Nurse (RN 3) Supervisor on duty, because RN 3 was from a Nursing Registry (a nurse who works on an as needed or temporary basis through an agency) and she thought LVN 2 who was a regular facility staff who knew Resident 1 better would be able to help her. LVN 1 stated when 911 paramedics arrived, she recalled the RN 3 got upset because she was not notified of Resident 1's condition. LVN 1 stated RN 3 informed them (LVN 1 and LVN 2) that Resident 1's low BS levels, hypotension, and ALOC was an emergency situation that warranted a 911 call. During a telephone interview on [DATE] at 12:11 PM with CNA 1, CNA 1 stated the morning of [DATE], Resident 1 had refused to eat breakfast in the morning. CNA 1 stated when she went to Resident 1's room around 9 AM to 10 AM, Resident 1 looked pale and was not acting like his normal self. CNA 1 stated Resident 1 did not respond to any questions and only responded with a grunt (a noise that is a byproduct of the body's struggle to compensate for the decreased muscle strength). CNA 1 stated she notified LVN 1 and LVN 1 took the resident's blood pressure and blood sugar. CNA 1 stated she remembered LVN 2 coming in Resident 1's room and LVN 1 told LVN 2 to call 911 emergency services and LVN 2 responded that the licensed nurses cannot send Resident 1 out like that becaus [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on observation, interview, and record review, the facility failed to ensure Resident 7's gastrostomy feeding tube (GT - a tube that is passed through the abdominal wall to the stomach used to provide nutrition) removal was implemented as ordered by the physician on 2/8/2025, for one of three sampled residents (Resident 7) by failing to: 1. Timely follow up following a recommendation from Physician Assistant (PA) 1 when PA1 could not remove R7's GT. PA1 referred Resident 7 to a gastrointestinal (GI) specialist (doctor who specializing in stomach issues) on 2/10/2025.Facility staff failed to refer Resident 7 to a GT specialist until 3/14/2025 (32 days after PA 1's recommendation). Resident 7's GT specialist appointment was scheduled for 4/25/2025, over two months after PA1 made the original referral. This deficient practice resulted in severe resistance of the resident's unused GT, due to the delay of Resident 1's GT removal. This deficient practice has the potential to cause further GT complications such as infection due to not being flushed for several weeks. Findings: During a review of Resident 7's Admission Record [AR] indicated Resident 7 was originally admitted to the facility on [DATE], with diagnoses that included a history of acute respiratory failure (a life threating condition where the lungs can't deliver oxygen to the blood) and type 2 diabetes mellitus (high blood sugar levels in the body). During a review of Resident 7's Care Plan titled Resident on enhanced barrier precaution (infection control measure) precaution related to an indwelling device (a device inside the body) revised on 12/11/2024, the care plan indicated Resident 7 will have no signs and symptoms of infection related to the indwelling device. During a review of Resident 7's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) signed by MD 1 on 8/27/2025, the HPE indicated Resident 7 had the capacity to understand and make decisions During a review of Resident 7's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/13/2025, the MDS indicated the Resident 7's cognition (thought process) was intact. During a review of Resident 7's Telephone Orders (TO) dated 9/6/2024, the TO indicated enteral feed (nutrition given through a tube into the stomach) order Glucerna 1.5 Cal (unit of measurement) via continuous pump at a rate of 40 ml (unit of measure) times 20 hours. During a review of Resident 7's TO dated 11/4/2024, indicated for Resident GT to be flushed with 30ml of water every 6 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's TO dated 1/11/2025, the TO indicated Resident 7 was placed on oral diet of carbohydrate control, regular texture with thin liquid consistency. During a review of Resident 7's TO dated 2/6/2025, the TO indicated Resident 7's GT feeding was discontinued due to a new oral diet order. During a review of Resident 7's Nutritional Progress Notes dated 2/6/2025 timed at 4:27 PM, the Progress Note indicated Resident 7 was on carbohydrate control (diet more managing blood sugar levels) oral diet, regular texture. During a review of Resident 7's TO dated 2/8/2025 timed at 4:04 PM, the TO indicated Resident 7 may have GT removed by the wound specialist (PA 1). During a review of Resident 7's Wound Note, dated 2/10/2025, written by PA 1, the Note indicated PA 1 could not remove Resident 7's GT secondary to severe resistance and recommended Resident 7 to be sent to a GI specialist, for proper removal. The Note indicated PA 1 communicated to the facility's charge nurse and registered nurse. Further review of R1's chart lacked evidence that facility staff completed the referral to a GI specialist, as PA1 had recommended. During a review of Resident 7's Nurses Progress Note dated 3/14/2025 timed at 4:49 PM, the Note indicated Resident 7 was seen by the Nurse Practitioner (NP) 1 with a second recommendation for a referral to a GI specialist to remove GT. During a review of Resident 7's TO dated 3/14/2025, the TO indicated an order for GT removal with a GI specialist. The TO indicated the facility's case manager would follow up on insurance authorization. Further review of R7's chart lacked evidence the referral was made until 4/8/25. During a review of Resident 7's TO dated 4/8/2025, almost a month after NP1's order, a TO indicated Resident 7's GI specialist appointment with a schedule date of 4/25/2025 at 11 AM for GT removal. The appointment was over two months from PA1's original recommendation that R7 be referred to a GI specialist. During an interview on 3/25/2025 at 10:22 AM, PA 1 stated that on 2/8/2025, MD 1 ordered to remove Resident 7's GT. PA 1 stated on 2/10/2025, she was at the facility to remove Resident 7's GT and attempted to remove the GT three times, but the GT's anchor would not collapse. PA 1 stated there was some slight bleeding from the resident's GT site and she placed a dressing over it. PA 1 stated she wrote her report in Resident 1's records (Wound Note) and notified the charge nurse and the registered nurse supervisor. PA 1 stated she did not notify MD 1 that Resident 1's GT was not removed because the licensed nurses were made aware. PA 1 stated the licensed nurses should have read her Wound Note and notified MD 1. PA 1 stated since the licensed nurses did not notify MD 1 that GT was still in placed, this could result in the resident's GT to further clog and risk for Resident 7 to get an infection at the GT site. During an interview on 3/25/2025 at 10:47 AM, Resident 7 stated he wanted the GT removed because there was no need for it and that he has been tolerating oral diet. Resident 7 stated that he had been eating food for the past six weeks. Resident 7 stated the GT feeding had been discontinued, and the licensed nurses had stopped flushing the tube with water at the same time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2025 at 11:05 AM, Licensed Vocational Nurse (LVN) 7 stated that Resident 7 GT had been inactive for several weeks, and Resident 7's GT feedings were stopped several weeks ago. LVN 7 stated the GT medications were switched to oral medications and the GT had not been flushed for several weeks. LVN 7 stated she did not know Resident 7's GT was not removed by PA 1 on 2/10/2025. During a concurrent interview on 3/27/2025 at 3:30 PM and record review of Resident 7's Nursing Progress Note dated 2/10/2025 to 3/13/2025, the Interim Director of Nursing (IDON) stated there was no evidence that the licensed nurses followed up on PA 1's recommendation to have a GI specialist remove Resident 7's GT. The IDON stated that failing to follow up on PA 1's recommendation resulted in the delay in Resident 1's GT removal and had the potential for the GT to further clog and could result in an infection from the unused GT. The IDON stated the licensed nurses should have followed up with MD 1, but failed to call MD 1 until four weeks later. During a review of the facility's policy & procedure (P&P) titled Changing a Percutaneous Endoscopic Gastrostomy Tube revised on 11/2018, the P&P indicated to report complications promptly to the supervisor and the attending physician and report other information in accordance with facility policy and professional standards of practice. During a review of the facility's P&P titled Enteral Feedings - Safety Precautions revised on 11/2018, the P&P indicated to ensure the safe administration of enteral nutrition. The P&P indicated the facility will remain current in and follow accepted best practices in enteral feeding. The P&P indicated recognizing and reporting other complications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 6) who was receiving hemodialysis (HD - process of removing waste products and excess fluid from the body) treatments received care in accordance with professional standards of practice and in accordance with the facility's Policy & Procedure (P&P) on Dialysis Care, by failing to: 1. Ensure that facility staff completed Resident 6 Post Hemodialysis Treatment status, in accordance with the facility's P&P on Dialysis Care. 2. Ensure to assist Resident 6 ready for scheduled HD, three days a week, with a scheduled transportation and pick up time of 12:30 PM at the facility, every Mondays, Wednesday and Fridays. This deficient practice resulted in frequent delays in the resident's dialysis treatment sessions and had the potential to result in serious health complications. Findings: During a review of Resident 6's Admission Record [AR] indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included a history renal failure (kidneys (organ in the body responsible for removing waste) stop working) and type 2 diabetes mellitus (high blood sugar levels in the body). During a review of Resident 1's Hemodialysis care plan, revised on 10/8/2024, the care plan documented a goal that Resident 1 would have no complications related to hemodialysis. The interventions included Resident 1's scheduled hemodialysis treatments every Mondays, Wednesday and Fridays with transportation pick up time at the facility of 12:30 PM. A review of Resident 6's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) signed by the attending physician on 11/23/2024, documented that Resident 6 had the capacity to understand and make decisions. A review of Resident 6's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/14/2025, documented that Resident 6's cognition (thought process) was intact. During a review of Resident 6's Order Summary Report dated 3/2025, the Report documented that Resident 6 pick-up time for Hemodialysis was scheduled at 12:30 PM and Resident 6 chair time (time that the dialysis treatment typically starts) was at 1:45 PM. During a review of Resident 6's Order Summary Report dated 3/2025, the Report documented that Resident 6 pick-up time for Hemodialysis was scheduled at 12:30 PM and Resident 6 chair time (time that the dialysis treatment typically starts) was at 1:45 PM. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's Hemodialysis Communication Record for February and March 2025, the resident's Hemodialysis Communication Records failed to document Resident 1's Post Hemodialysis Treatment status, including the date/time Resident 6 returned to the facility from the Dialysis Center. The Hemodialysis Communication Records for 3/24/25, 3/21/25, 3/19/25, 3/17/25, 3/14/25, 3/7/25, 3/3/25, 2/28/25, 2/26/25, 2/24/25, 2/21/25, 2/19/25, 2/14/25, 2/12/25, 2/10/25, and 2/7/25 lacked documentation of vital signs, dialysis site status for swelling/drainage/pain, and monitoring for post hemodialysis complications that included dizziness, vomiting, nausea, fatigue, hypotension, or none; and lacked Resident 1 's licensed nurse's signature. During a review of Resident 6's Nursing Progress Note dated 3/17/2025 at 1:30 PM, the Note documented that Resident 6 left the facility for a dialysis appointment. The Progress Note did not document what time Resident 6 left the facility and did not indicate when Resident 6 returned back to the facility. The Progress Note did not document Resident 6's status upon returning from the Dialysis appointment. During a review of Resident 6's Nursing Progress Note dated 3/19/2025 at 1:04 PM, the Progress Note documented that Resident 6 left the facility for her dialysis appointment. The Progress Note did not document what time Resident 6 left the facility and did not document when Resident 6 returned back to the facility. The Progress Note did not document Resident 6's status upon returning from the Dialysis appointment. During a review of Resident 6's Nursing Progress Note dated 3/24/2025 at 12:30 PM, the Progress Note documented that Resident 6 left the facility for her dialysis appointment. The Progress Note did not document what time Resident 6 left the facility and it did not document what time Resident 6 returned to the facility on [DATE]. The Progress Note did not document Resident 6's status upon returning from the dialysis appointment. During a telephone interview on 3/25/2025 at 10 AM with the Dialysis Center Secretary (DCS), the DCS stated that Resident 6 had a pickup time from the facility that was scheduled for 12:30 PM every Mondays, Wednesdays, and Fridays to go to Ddialysis appointments because Resident 6's chair time at the Dialysis Center is 1:45 PM. The DCS stated that Resident 6's pickup time from the facility was constantly delayed about 20 minutes to 30 minutes. As a result, Resident 6 would arrive at the Dialysis Center around 2:20 PM. The DCS stated that if Resident 6 did not arrive at the assigned chair time, it would be given to the next resident that was waiting at the Dialysis Center. The DCS stated that Resident 6 dialysis appointments would sometimes start around 3 PM to 4 PM because of the delay and would finish around 7 PM to 8 PM. The DCS stated if Resident 6 started at her assigned chair time of 1:45 PM, then her dialysis sessions would have been finished between 5:30 PM to 6 PM. The DCS stated that on 3/24/2025, Resident 6 arrived at the Dialysis Center at 2:30 PM and her dialysis session finished at 7 PM. The DCS stated on 3/24/2025, there were issues with the facility's transportation and the facility driver failed to picked up Resident 6 until 10:30 PM. The DCS stated she spoke with the facility staff 7 PM, and again at 8:30 PM, because there was no transportation to pick up Resident 6 not until 10:30 PM that night. (continued on next page)

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	056487	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2025 at 1:15PM, Resident 6 stated that the dialysis transportation would arrive on time at the facility, but nursing staff would make the driver wait because the staff failed to help her get ready prior to her dialysis appointment. Resident 6 stated she would leave the facility at around 1 PM or 1:30 PM, instead of the scheduled pick-up time of 12:30 PM. Resident 6 stated that on 3/24/2025 she left the facility late again, then her dialysis was delayed and she had to start late and finished at around 7 PM to 8 PM. Resident 6 stated that the transportation was late picking her up at a later time because of the delay in her dialysis treatments. Resident 6 stated she returned to the facility late at around 10:30 PM or 11 PM. Resident 6 stated she was upset, tired, and was unable to get sleep that night. During an interview on 3/25/2025 at 1:47 PM, the facility's Social Worker (SW 1), SW 1 stated Resident 6 had a scheduled pick-up time of 12:30 PM on Mondays, Wednesday, and Fridays. SW 1 stated on 3/24/2025 Resident 6 was late for her dialysis appointment and was unable to recall what time Resident 6 left for the Dialysis Center. SW 1 stated she received a phone call from the Dialysis Center on 3/24/2025 around 7 PM because the driver had not picked up Resident 6 SW 1 stated when she contacted the transportation company, the company stated they were able to pickup Resident 6 at the Dialysis Center at around 10:30 PM. SW 1 stated that the facility's nursing staff should have followed the scheduled pick-up time of Resident 6 at 12:30 PM during dialysis days and had Resident 6 ready for pick up at 12:30 PM, then, Resident 6 could have started dialysis chair time on time at 1:45 PM and returned to facility at around 6 PM. SW 1 stated Resident 6's scheduled pick up time from the Dialysis Center every Mondays, Wednesdays, and Fridays' was 4:30PM. During a concurrent interview on 3/27/2025 at 2:10 PM and record review of Resident 6 Hemodialysis Communication Records dated 2/7/2025 to 3/24/2025, Interim Director of Nursing (IDON) stated that Resident 6's Hemodialysis Communication Records failed to document the time Resident 6 left the facility for the dialysis center and failed to document what time Resident 6 returned back to the facility. The IDON stated Resident 6's Hemodialysis Communication Records does not have documented evidence if the licensed nurses performed an assessment of Resident 6 after coming back from dialysis appointments. During a concurrent interview on 3/27/2025 at 2:10 PM and record review of Resident 6's Nursing Progress Notes dated 3/17/2025, 3/19/2025, and 3/24/2025, the IDON stated Resident 6's Progress Notes did not document what time Resident 6 left the facility for the Dialysis Center and did not indicate document what time Resident 6 returned back to the facility. The IDON stated that the facility's' nursing staff should have had Resident 6 ready at the scheduled time pick-up time of 12:30 PM, but Resident 6 was always not up and ready by 12:30 PM during Dialysis appointments. The IDON stated the delay in getting Resident 6 ready to leave the facility for Dialysis appointments at 12:30 PM contributed to the transportation delays in Resident 6's arrival at the Dialysis Center and also contributed to the delay in picking up Resident 6 on 3/24/2025. The IDON stated the transportation company ended up picking up Resident 6 back to the facility after 10:30 PM on 3/24/2025. The IDON stated this delay could have caused harm to Resident 6 because of the late dialysis treatments, fatigue, hunger, and not returning to the facility on time to rest after Dialysis treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled Dialysis Care dated 8/25/2021, documented that the facility would provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments. The policy documented that the Facility would arrange transportation to and from the dialysis provider, as well as for meals (if necessary), medication administration, and a method of communication between the dialysis provider and the Facility. The policy documented that nursing staff would communicate the following information in writing to the Dialysis Staff: The resident's current vital signs, any changes of conditions specific to the resident with each treatment; and that the Dialysis Provider would communicate in writing to the Facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required., Nursing Staff would keep the Attending Physician, the resident, and the resident's family informed of any change in conditions and nursing staff may use hemodialysis communication record. The policy documented that all documentation concerning dialysis services and care of the dialysis resident would be maintained in the resident's medical record, the Dialysis Communication Record, and that the nursing staff would send a dialysis communication form to the dialysis center every time a resident was scheduled for off-site dialysis. The provider's dialysis nurse would be responsible for documentation of dialysis treatments and documentation would be maintained in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to maintain accurate documentation in accordance with accepted professional standards and practices for one of three sampled residents (Resident 6) by ensuring Residents 8's weight was accurately recorded in the resident's records on 2/8/2025 and 3/6/2025. Resident 6's weight on 2/8/2025 was recorded as 169.4 lbs. (unit of measurement) on the Hemodialysis Communication Record - Post (after) Dialysis Treatment but the Weight Vitals Summary Record indicated on 3/6/2025 Resident 6's weight was 116.4 lbs. which was a 53 lbs. difference. This deficient practice had the potential to result in inaccurate assessments and interdisciplinary team (IDT) recommendations for Resident 1's care and management of current medical condition that included diagnoses of renal failure (a condition where the kidneys lose their ability to filter waste products from the blood) and diabetes mellitus (a chronic condition where the body cannot regulate blood sugar (glucose) levels effectively). Cross reference to F698 Findings: During a review of Resident 6's Admission Record [AR], the AR indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included renal failure and Type 2 diabetes mellitus. During a review of Resident 6's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) dated 11/23/2024, the HPE indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/14/2025, the MDS indicated the Resident 6's cognition (thought process) was intact. During a review of Resident 6's Monthly Weights dated 2/5/2025, the Monthly Weights record did not have a documentation of Residents 8's weight upon admission to the facility on [DATE]. During a review of Resident 6's Nutritional assessment dated [DATE], written by Registered Dietitian (RD)1, the Assessment indicated Resident 6's post dialysis weight was 169.4 lbs. During a review of Resident 6's Weights and Vitals Summary, the summary indicated that Resident 6's weight on 2/8/2025 was recorded as 169.4 lbs. from the Hemodialysis Communication Records Post Dialysis Treatment. During a review of Resident 6's Hemodialysis Communication Records dated 3/3/2025, the Record indicated Resident 6's post dialysis weight was 167.6 lbs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's Weights and Vitals Summary, the summary indicated that on Resident 6's weight on 3/6/2025 was recorded at 116.4 lbs. from the Hemodialysis Communication Records Post Dialysis Treatment. During a review of Resident 6's Hemodialysis Communication Records dated 3/7/2025, indicated Resident 6's post dialysis weight was 173.8 lbs. During a review of Resident 6's Registered Dietitian (RD) Monthly Weight Variance Review dated 3/18/2025, the RD Monthly Weight Variance Review indicated Resident 6's current weight was 116.4 lbs. The RD Review indicated that Resident 6 had a 55 lbs. weight loss with a comparison weight of 169 lbs. from 2/8/2025. The RD Review indicated under RD evaluation that the resident's weight loss was likely related to fluid shifts with dialysis and weight loss was unavoidable. The RD Review indicated that weight loss may be beneficial due to the resident being overweight for short stature. During an interview on 3/25/2025 at 11:20 AM, Rehab Nursing Assistant (RNA 1) stated that he is responsible for weighing the residents during the day shift for the weekly and monthly resident weights. RNA 1 stated there was a logbook for resident's weights that he fills out and documents residents' weights. RNA 1 stated that if a resident was a new admit, the Certified Nurse Assistants (CNA) and Charge Nurse are responsible for weighing the residents especially dialysis residents. During an observation of Resident 6's weight on 3/25/2025 at 11:50 AM, CNA 8 and RNA 1 entered Resident 6's room with a Hoyer Lift (a devise used to weight and transfer residents with mobility challenges) to weigh Resident 6. RNA 1 calibrated the Hoyer lift indicated by mark of two zeros on the digital display. RNA 1 and CNA 8 both stated that Resident 6's weight taken from the Hoyer Lift weighing scale was 165 lbs., (as opposed to the recorded weight of 116.4 lbs. in the RD Monthly Weight Variance Review on 3/18/2025). During a concurrent interview on 3/25/2025 at 12:05 PM and record review of Resident 6 Weights and Vitals Summary record, RNA 1 stated that the weights documented on Resident 6's Weights and Vitals Summary record dated 2/8/2025 and 3/6/2025 were weights copied from the Hemodialysis Communication Record Post Dialysis Treatment. RNA 1 stated that the facility staff should re-weigh Resident 6 prior to recording the weights on Resident 6's Weights and Vitals Summary record and not copy the weights indicated in Resident 6's post dialysis treatment records to get an accurate weight. RNA 1 stated that Resident 6 weight on 3/6/2025 of 116.4 lbs. as indicated on the Weights and Vitals Summary record was an incorrect weight and Resident 6 should have been reweighed immediately after the dialysis treatment. During a concurrent interview on 3/26/2025 at 12:50 PM and record review of Resident 6's Registered Dietitian Monthly Weight Variance Review dated 3/18/2025 with the RD 1, RD 1 stated that Resident 6 had a weight recorded of 116.4 lbs. which was a significant weight loss with no new recommendation. RD 1 stated that she took Resident 6's weight from the Hemodialysis Communication Records. RD 1 stated she did not ask the facility staff to reweigh the resident on 3/18/2025 during her in-person evaluation. RD 1 stated that she did not recommend for Resident 6 to be reweighed. RD 1 stated that Resident 6 should have been reweighed on 3/6/2025 and when asked why RD 1 did not report to the nurses the discrepancy of the weight records, RD 1 had no answer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 2:50 PM and record review of Resident 6 Monthly Weights dated 2/5/2025, the Interim Director of Nursing (IDON) stated Residents 8's weights was not recorded accurately for 2/5/2025 and 3/6/2025. The DON stated that nursing staff should have reweighed Resident 6 to have an accurate weight and not copy from any other records. In a concurrent record review of Resident 6's Hemodialysis Communication Record dated 3/3/2025 with the IDON, the IDON stated that Resident 6 hemodialysis communication records indicated Resident 6's post dialysis weight was 167.4 lbs. and for 3/7/2025 Resident 6's post dialysis weight was 173.8 lbs. which were a big difference from the resident's recorded weight of 116.4 lbs. During a review of Resident 6's Weights and Vital Summary on 3/27/2025 at 2:50 PM, the IDON stated Resident 6's weight on 3/6/2025 was 116.4 lbs. The IDON stated that Resident 6 weight on 3/6/2025 was incorrect and that the nursing staff and RD 1 should have noticed the weight was incorrect. The IDON stated that by not accurately documenting the correct weight would have harmed Resident 6 with her fluid balance because she is a dialysis resident. During a review of the facility's P&P titled Guideline for Charting and Documents revised 4/2012, indicated the purpose of charting and documentation is to provide: a complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care, guidance to the physician in prescribing appropriate medications and treatments, the facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident, nursing service personnel with a record of the physical and mental status of the resident, assistance in the development of a Plan of Care for each resident. The P&P indicated document the iet, appetite, food consumption, eating habits, assistance needed and where, diet normally consumed, weight variations, hydration status, fluid intake, tolerance of tube feeding, etc. During a review of the facility's P&P titled Weight Management revised 4/2012, indicated the facility will obtain baseline weight and identify significant weight change, to determine possible causes of significant weight change and each individual's weight will be obtained and documented upon admission to the facility. The P&P indicated Nursing will be responsible for obtaining each individual's initial weight. The P&P indicated the nursing facilities, weights will be obtained weekly for 4 weeks after admission, the registered dietitian or designee will be responsible for determining the desirable weight range or usual body weight range and staff will follow acceptable procedure to obtain accurate weights