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	04/03/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, record review, the facility failed to ensure adequate supervision is provided and residents are free of accident hazards to prevent injuries for 5 of 13 sampled residents (Residents 7, 8, 9, 10 and 11) in accordance with the facility's policy and resident's care plan for smoking by failing to: 1. Prevent a smoking-related incident in which Resident 7's linens were burned inside the resident's room while three roommates were in the room. 2. Provide supervision and monitoring to Residents 3, 4, 5 and 6 for safely smoking by conducting an Interdisciplinary Team (IDT- a group of facility staff that plan the care for the residents) to discuss about risk and benefit of smoking safely prior to allowing the residents keep in their possession and/or access to smoking materials. These deficient practices had the resulted in Resident 7 and his roommates, staffs and visitors' safety due to risk for burn from fire or smoke inhalation (damaging the airways and lungs, potentially leading to difficulty breathing, lung damage, and even death due to lack of oxygen). Findings: 1. During a review of Resident 7's Admission Record, indicated the facility admitted Resident 7 on 10/19/2023 and readmitted on [DATE] with diagnoses including with diagnoses including heart failure (heart can't pump enough blood to meet the body's needs or demand) and diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin). During a review of Resident 7's History and Physical Examination (H&P), dated 10/26/2023 indicated, Resident 7 had the mental capacity to make medical decisions. During a review of Resident 7's Care Plan for Smoking, dated on 10/27/2023, revised on 3/24/2025 indicated Resident 7 may smoke with supervision. The care plan goal indicated Resident 7 may smoke in designated area safely x (times) 90 days. The interventions included the facility will supervise Resident 7 when smoking in accordance with assessed needs; monitor resident's compliance to smoking policy and maintain resident's smoking materials at the nurses' station. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's Interdisciplinary Notes (IDT) notes dated 4/10/2024, indicated an IDT meeting was held on 4/10/2024 to address resident behaviors related to nicotine (is a chemical in tobacco, which is used in cigarettes, cigars, pipes tobacco, chewing tobacco, some vaping liquids) use. Resident is alert and oriented, acknowledged the concerns, and signed the facility's behavior contract. Resident is adjusting well with no current questions or concerns. During a review of Resident 7 IDT notes dated 5/14/2024 indicated the IDT met with the resident, using a translator to discuss the risks of smoking in unauthorized areas. Resident 7 was encouraged to follow the scheduled smoking times, and the resident agreed. During a review of Resident 7 's smoking evaluation form, dated 2/12/2025 indicated Resident 7 required supervision when smoking due to poor safety judgement. During a review of Resident 7's Change in Condition (COC) Evaluation form, dated 4/02/2025 indicated Resident 7 was smoking in bed and setting fire to bed linen on 4/2/202 at 12:50 AM During a review of Resident 7 IDT notes dated 4/2/2025 indicated the IDT met with the resident, to discuss smoking incident when the staff responded to a smoke in Resident 7's room and found burn marks on a towel and bedding. There were no injuries noted. Police were notified, and a lighter was confiscated. Roommates were unharmed and had no concerns. Resident was placed on 1:1 (one resident and one staff) monitoring. Resident 7 expressed a desire to smoke freely and agreed to discharge to a lower level of care. MD approved the discharge. During an interview with the Interim Director of Nursing (IDON) on 4/3/2025 at 6:51 PM, the DON stated Resident 7 was known to be noncompliant with the smoking policy and the facility was not aware that Resident 7 kept cigarettes and lighter in his possession. 2. During a review of Resident 8's Admission Record, indicated the facility admitted Resident 8 on 1/27/2017 and readmitted on [DATE] with diagnoses including hypertension (high blood pressure) and heart failure. During a review of Resident 8's H&P, dated 3/18/2024 indicated, Resident 8 had the mental capacity to make medical decisions. During a review of Resident 8's Smoking Evaluation Form, dated 2/12/2025 indicated Resident 8 required supervision with smoking due to poor safety judgement. During a review of Resident 8's Care Plan for Smoking, initiated on 2/27/2025, indicated Resident 8 may smoke with supervision. The care plan goal indicated Resident 8 will smoke in designated area safely x 90 days per smoking assessment. The interventions included the facility will explain the risk and benefit of smoking safety and will supervise the resident with smoking in accordance with assessed needs and maintain patients smoking materials at nurses' station. During an observation in the patio area and concurrent interview on 4/4/2025 at 2:45PM, Resident 8 had a cigarette and a lighter in the pocket of his wheelchair. In an interview Resident 8 stated, he has possession of his lighter and cigarettes because it is his property so he will hold on to them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 9's Admission Record, the facility admitted Resident 9 on 11/23/2022 and readmitted on [DATE] with diagnoses including hemiplegia (unable to move one side of the body) and hemiparesis (severe loss of strength to one side of the body) of the left side of the body and depression (severe sadness and hopelessness). During a review of Resident 9's H&P, dated 12/25/2024 indicated, Resident 9 had the mental capacity to make medical decisions. During a review of Resident 9's Care Plan for Smoking, initiated on 2/27/2025, indicated Resident 9 may smoke with supervision. The care plan goal indicated for the resident to smoke in a designated area safely x 90 days per smoking assessment. The interventions indicated the facility will explain risk and benefit supervise patient with smoking in accordance with assessed needs. During an observation on 4/3/2025 at 3:38 PM, in the smoking patio, Resident 9 was observed smoking with a staff supervising the area. Resident 9 had a lighter and stated it was her right to keep the cigarette and lighter in her possession. Then Resident 9 proceeded to place the lighter in a pouch in her wheelchair. 4. During a review of Resident 10's Admission Record, the facility admitted Resident 10 on 7/14/2023 with diagnoses including hypertension and diabetes mellitus. During a review of Resident 10's H&P, dated 7/18/2023 indicated, Resident 10 had the mental capacity to make medical decisions. During a review of Resident 10's Smoking Evaluation Form, dated 2/12/2025 indicated Resident 10 required supervision while smoking due to poor safety judgment. During a review of Resident 10's Care Plan for Smoking, initiated on 2/27/2025, indicated Resident 10 may smoke with supervision. The goal is for the resident to safely smoke in designated areas for 90 days, as indicated by the smoking assessment. Interventions include educating the resident on the risks and benefits of smoking and providing supervision during smoking in accordance with the resident's assessed needs. A review of Resident 10's clinical record indicated an IDT was not conducted to discuss with the resident about risk and benefit of smoking safely. During an observation and concurrent interview on 4/3/2025 at 2:39 PM, in Resident 10's room, Resident 10 had a box of cigarettes on top of a walker that belonged to Resident 10. Resident 10 stated she holds on to the cigarettes because it is her right to keep her possession. Resident 10 was not observed smoking in the room. 5. During a review of Resident 11's Admission Record (Face Sheet), the facility admitted Resident 11 on 3/14/2025 with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated) and heat failure. During a review of Resident 11's History and Physical (H&P), dated 3/15/2025 indicated, Resident 11 had the mental capacity to make medical decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's Smoking Evaluation Form, dated 3/14/2025 indicated Resident 11 was not allowed to smoke due to not being able. During an observation of the Smoking Patio on 4/3/2025 at 12:23 PM, Resident 11 pulled a cigarette out of his hospital gown pocket and lit his own cigarette with another resident's cigarette and started smoking. During an interview with Resident 11 on 4/3/2025 at 12:45PM, Resident 11 stated he smoked a few times a day. When asked where the residents lighter and cigarettes were kept, Resident 11 stated he kept the cigarettes at his bedside. During a review of Resident 11's Care Plans from 3/14/2025-4/3/2025, indicated no evidence a care plan was developed for smoking and an IDT meeting was not conducted to discuss with the resident about the risk and benefit of smoking safely. During an interview on 4/3/2025 at 11:45 AM, Licensed Vocational Nurse 1 (LVN 1) stated she was not aware that residents kept cigarettes and lighters in their possession. LVN 1 stated the residents cannot have lighters with them due to fire and safety reasons and because there are residents on oxygen. During an interview on 4/3/2025 at 2:50 PM, Registered Nurse 1 (RN 1) stated residents are not allowed to have lighters with them due to safety issues, the safety of others, and the presence of oxygen in the residents' rooms. RN 1 stated once residents finished smoking the lighters are collected by the staff supervising the smoking area. RN 1 stated some residents do keep cigarettes and lighters in their possession, but I confiscated them because they should not keep cigarettes and lighters with them. During a concurrent interview and record review on 4/3/2025 at 6:59PM, with the IDON stated, all the residents that smoke should go through an IDT meeting to discuss about resident's right and to determine if it's safe for them to retain cigarettes and lighters without supervision and a care plan should be developed about smoking safety. The IDON stated according to record review only 3 residents out of 13 residents that smokes attended an IDT meeting to discuss about safe smoking and importance of compliance with the policy. During a review of the facility's policy and procedure (P&P) titled, SMOKING, dated 08/09/22, indicated that the Licensed Nurse will evaluate residents who express a desire to smoke and present the evaluation to the Interdisciplinary Team (IDT). The IDT is required to develop an individualized plan for safe storage, use of smoking materials, and supervision as needed. The policy further noted that residents requiring supervision or monitoring for safety are not allowed to retain smoking materials or smoke unaccompanied.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on interview and record review, the facility failed to ensure residents who displayed psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem and provided behavioral health services for one of two sampled residents (Resident 1), whose primary diagnosis was alcoholic cirrhosis (a serious liver condition caused by heavy alcohol consumption, where healthy liver tissue is replaced by scar tissue) and had a behavior of going out of the facility to the liquor store. 1. Social Services Director (SSD) 1 failed to refer Resident 1 to a psychiatrist and/or psychologist for appropriate counseling and behavioral services for alcoholism, in accordance with Resident 1 ' s written Behavioral Contract. 2. SSD 1 and the facility ' s licensed nurses failed to develop and implement person-centered care plans that included and support the behavioral health care needs, identified in Resident 1 ' s Behavioral Contract, SSD 1 ' s evaluation of Resident 1 dated 4/8/2024 and SSD 2 ' s observations of Resident 1 ' s behavior on 3/11/2025, 3/19/25 and 3/27/25. This deficient practice had the potential to cause complications (an unfavorable result of a disease, health condition, or treatment) of Resident 1 ' s alcoholism, can negatively affect Resident 1 ' s quality of life. Findings: 1. During a review of Resident 1 ' s, Admission Record (AR), dated 4/2/2025, the AR indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of alcoholic cirrhosis of the liver, chronic kidney disease (kidneys are damaged and can't filter blood effectively, leading to waste buildup and other health problems) and hypertension (elevated blood pressure). During a review of Resident 1 ' s Social Services Progress Notes, authored by the Social Services Director (SSD 1), dated 4/8/2024, SSD 1 ' s Progress Note indicated, Evaluation completed for resident [Resident 1] with diagnosis of substance abuse and use [Alcohol Cirrhosis of Liver]. Resident [1] has adapted well to the facility, no substance abuse occurred in the facility. Had a conversation with the resident and offered psychiatrist and psychologist consult and resident agreed to be seen. Resident [1] also informed and is in agreement for checking belongings every quarter and as necessary through inventory. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Behavioral Contract signed by Resident 1 on 4/9/2024, the Contract indicated the facility ' s Interdisciplinary Team (IDT) is proposing a behavioral contract to Resident 1 to facilitate compliance with facility rules, care plan adherence, and/or to promote optimal health, safety, and well-being for self and others. The Contract indicated the Specific Safety Issues, Behavioral Problems are [Behavior] related to diagnosis of Alcohol Cirrhosis of Liver. The Behavioral goals of the contract indicated Resident [1] will be referred to Psych services [Psychiatrist/Psychologist] and Resident [1] will obtain redirection as needed. The Contract further indicated for the resident to write Specific Things [Resident 1] will not do, and the contract indicated Resident 1 agreed and wrote I won ' t drink alcohol, I have not in years. The Contract indicated if Resident 1 choose not to comply with the contract, the consequence/s would be Redirection. A review of Resident 1 ' s clinical record indicated no documented evidence found in Resident 1 ' s care plans that a person-centered care plan was developed and implemented from this Behavioral Contract and Agreement made between Resident 1 and the facility ' s Interdisciplinary Team [IDT], including the Social Services Director (SSD 1). During a review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment tool) dated 3/1/2025, the MDS indicated Resident 1 ' s cognitive status (the mental process of thinking and understanding) was intact. MDS indicated Resident 1 independent with eating, set-up or clean-up assistance (helper sets up and clean up) with personal hygiene and partial/moderate assistance (helper does less than half the effort) with toileting and bathing. During a review of Resident 1 ' s care plans (CP) since being admitted to the facility on [DATE], the following care plans were developed for Resident 1 for the diagnosis of Alcoholic Cirrhosis of the Liver and behavior/mental issues: 1. The CP developed on 7/11/2023 and revised on 3/31/2025, the CP indicated Resident 1 was at risk for Falls due to diagnoses that included Alcoholic Cirrhosis. The CP indicated some of the contributing factors were poor balance and antihypertensive medications. The CP interventions included assessments and monitoring for changes in mental/medical status, and to encourage the resident to attend all activities that maximizes their full potential while meeting their needs to socialize. 2. The CP developed on 10/11/2023 and revised on 3/31/2025, the CP indicated Resident 1 was at risk for Alteration in Comfort due to diagnoses that included Alcoholic Cirrhosis. The CP indicated a goal of achieving acceptable level of pain control for 90 days. 3. The CP developed on 3/5/2023 and revised on 3/31/2025, the CP indicated Resident 1 was alert and oriented with periods of confusion and forgetfulness. The CP indicated a goal that Resident 1 will express satisfaction that his daily routines and preferences are accommodated by staff. The CP interventions included Resident 1 enjoying going outdoors to sit and relax. 4. Resident 1 ' s Care Plans did not include person centered care plans were developed for Resident 1 ' s behavioral health care needs specific to behaviors assessed for substance abuse/alcohol abuse, that included psychiatrist/psychologist consult, voluntary checking of personal belongings every quarter and as necessary, as indicated in the Social Services Evaluation and Progress Note on 4/8/2024 and observations documented by the SSD in Resident 1 ' s Progress Notes on 3/11/2025 and 3/19/2025. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 1:45 PM with the SSD 2, SSD 2 stated she saw Resident 2 rolling around his wheelchair outside of the facility near the construction site, on two occasions on 3/11/2025 and 3/19/2025. SSD 2 stated, she was not sure if Resident 1 was trying to go to the nearby liquor store because the liquor store was on the same street as the facility. SSD 2 stated SSD 2 stated Resident 1 was self-responsible and able to decision for himself. SSD 2 stated the facility did not develop a care plan , refer the resident to alcoholism (an addiction to the consumption of alcoholic liquor) such as a referral to Alcoholic Anonymous (AA-a fell owship of people who come together to solve their drinking problem) for Resident 1 ' s behavior concerns, and no referral was made for behavior health services to manage Resident 1 ' s possible psychosocial issues with alcohol abuse. SSD 2 stated, Resident 1 was not referred to psychiatrist and psychologist consultant related to behavior of alcohol abuse when the resident was observed going to the liquor store. During a concurrent interview and record review, on 4/2/2025, at 3 PM, with the IDON (Interim Director of Nurses), Resident 1 ' s electronic health records (EHR) from admission up to 4/2/2025 was reviewed. The DON stated, Resident 1 ' s records did not indicate documented evidence that a care plan for Resident 1 ' s behavior for potential for alcohol abuse was developed for Resident or any person-centered interventions were implemented to provide behavioral health services to Resident 1 that included counseling for Resident 1 ' s alcoholism such as a referral to Alcoholic Anonymous. The DON stated, not having a plan of care, and behavioral services such as AA, Resident 1 had the potential for worsening alcoholic condition, alcoholic behavior. During an interview on 4/2/2025 at 4:20 PM with IDON, IDON stated, Resident 1 should have been supervised, should have a care plan and discussed during IDT, and should be monitored frequently, and the need for behavioral health services such as psych counseling or AA should have been addressed, because of the potential for complications from alcoholism, potential for accidents or any type of incidents. During a review of the facility ' s policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated; a) an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s mental and psychosocial needs shall be developed for each resident b) each resident ' s care plan is designed to incorporate identified problem areas, incorporate risk contributing factors associated with identified areas, and c) aid in preventing and reducing declines in the residents functional status and/or functional level. During a review of the facility ' s policy and procedure (P&P) titled, Behavior Management revised 2/1/2023, the P&P indicated; a) Resident exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies the underlying medical, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the resident ' s behavior, and b) Staff must ensure that a Resident who displays with a psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial wellbeing. The policy and procedure did not indicate how the Behavior Contract will be implemented for residents identified with alcohol abuse.