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	04/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to report an allegation of physical abuse, for one of three sampled residents (Resident 2) who reported being punched on the leg by an unnamed nurse on 4/5/25, to the California Department of Public Health (CDPH), Ombudsman (a person who investigates, reports on, and helps settle complaints) and local law enforcement immediately or within two (2) hours in accordance to the facility ' s Policy and Procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. This deficient practice had the potential for facility staff to under report allegations of abuse placing Resident 2 at risk for further abuse and resulted in a delay in the investigation for Resident 2 ' s abuse allegation. Findings: During a record review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses including but not limited to infection of amputation stump (part of a limb that remains after an amputation surgery) of the right and left lower extremities (thigh, knee, ankle, foot, and toes), anxiety disorder (persistent and excessive worry that interferes with daily activities), and transient cerebral ischemic attack (a blockage of blood flow to the brain). During a record review of Resident 2 ' s Minimum Data Set (MDS, a resident assessment and tool), dated 4/5/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 2 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing self, and chair/bed-to-chair transferring. During a record review of Resident 2 ' s Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident ' s status), dated 4/5/2025, the COC indicated on 4/5/2025 at 2:30 PM, Resident 2 stated a nurse punched him in the leg. The COC did not indicate which nurse Resident 2 identified. During a record review of Licensed Vocational Nurse 4 ' s (LVN 4) interview statement, dated 4/8/2025, the statement indicated Resident 2 informed LVN 4 that a nurse punched his leg. The statement indicated LVN 4 informed Registered Nurse Supervisor 2 (RNS 2) of the abuse allegation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of RNS 2 ' s interview statement, dated 4/8/2025, the statement indicated LVN 4 did not inform RNS 2 of Resident 2 ' s allegation of abuse. During a record review of Resident 2 ' s care plan, dated 4/9/2025, the care plan indicated Resident 2 was at risk to exhibit psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) and/or emotional distress related to abuse allegation and Resident 2 alleged a nurse hit his leg. The care plan indicated staff interventions were to provide emotional support as needed based on the resident ' s response, encourage resident to verbalize feelings, and give support and reassurance. During an interview on 4/21/2025 at 11:05 AM with the Interim Director of Nursing (IDON), the IDON stated staff did not report Resident 2 ' s allegation of abuse to CDPH, Ombudsman, and local law enforcement. The IDON stated LVN 4 completed a COC for the abuse allegation on 4/5/2025 at 2:30 PM. The IDON stated LVN 4 should have should have notified CDPH, Ombudsman, and local law enforcement within two hours of the abuse allegation. The IDON stated reporting within the two-hour time frame ensured prompt investigation and prevention of further abuse. The IDON stated the IDON found out about the abuse allegation through a review of the nurses ' notes done on 4/7/2025. The IDON stated the IDON made the report on 4/7/2025 (2 days after the allegation of abuse) to CDPH, Ombudsman, and local law enforcement. The IDON stated Resident 2 ' s abuse allegation was not and should have been reported on 4/5/2025 when Resident 2 initially informed LVN 4 of the abuse allegations. During a concurrent interview and record review on 4/23/2025 at 10:12 AM with the IDON of the facility ' s policy and procedure (P&P), the IDON stated based on the facility ' s P&P any allegation of abuse should be reported to CDPH, Ombudsman, and local law enforcement officials within 2 hours of the allegation. During a record review of the facility ' s P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2022, the policy indicated if resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other official according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility The local/state ombudsman Law enforcement officials within two hours of an allegation involving abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to develop, revise and implement an individualized comprehensive care plan that included measurable and timetables to meet the resident's medical, physical, mental, and psychosocial needs, with an ongoing resident assessments and revisions as information about the resident and the resident's condition changed in accordance with the facility's policy and procedures for: 1a. Resident 3 with chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing)/oxygen (O2) therapy. 1b. Resident 3 with reddish/purplish discoloration/hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) to her right trunk area upon readmission to the facility from the General Acute Care Hospital (GACH) on 4/12/2025. 2.Resident 1 with moisture associated skin damage (MASD- caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus) and Stage 3 Pressure injury (full thickness tissue loss where the skin and underlying subcutaneous fat are damaged, but the bone, tendon, or muscle is not exposed). These deficient practices had the potential for the staff not to implement adequate interventions for Resident 3 to ensure sufficient oxygen therapy and respiratory intervention were provided. In addition, for Resident 3 and Resident 1 the deficient practice could result in worsened skin breakdown or hematoma that could lead to infection, discomfort, pain that required hospitalization for higher level of care. Cross Reference to F686 and F695 Findings: 1a. During a review of Resident 3's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included COPD cand CHF, morbid obesity (a severe form of obesity where a person's Body Mass Index [BMI, a number calculated from your height and weight that was used to classify people as underweight, healthy weight, overweight, or obese] was 40 or higher), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/6/2025, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 3 required substantial/maximal assistance (helper did more than half the effort) from facility staff for chair/bed-to-chair transfer. The MDS indicated Resident 3's active diagnoses included heart failure and COPD and did not have short breath or trouble breathing with exertion, when sitting at rest, and when lying flat. The MDS indicated Resident 3 did not have any respiratory treatments including oxygen (O2) therapy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's MAR (Medication Administration Record) indicated Resident 3 had no documented evidence Resident 3 received oxygen as needed from 4/17/2025 to 4/22/2025. During a review of Resident 3's Order Summary (a physician's order) dated 4/17/2025 at 1:32 PM, the Order Summary indicated to deliver oxygen at two liters per minute (2L/min, a way to measure the rate of flowing oxygen) via nasal cannula (NC, a medical device, a simple way to deliver supplemental oxygen) as needed for COPD. The Order Summary did not indicate parameters on what oxygen blood level or when to increase or decrease the oxygen therapy. During a review of Resident 3's Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident required oxygen on but did not indicate the amount of oxygen delivered from 4/17/2025 and 4/20/2025 to 4/22/2025. During a concurrent interview and record review of Resident 3's Progress Notes on 4/21/2025 at 4:19 PM, LVN 6 stated the resident's Progress Notes did not indicate the resident received oxygen. LVN 6 stated there should have been documentation Resident 3 received oxygen because that could affect the resident's safety, and the resident could decline. During an observation on 4/22/2025 at 7:51 AM in Resident 3's room, Resident 3 was sleeping in bed with the head of bed elevated at45 degrees angle receiving oxygen via NC at 2L/min. During a concurrent interview and record review of Resident 3's Comprehensive Care Plan on 4/22/2025 at 3:55 PM, RNS 3 stated Resident 3's Care Plan, dated 11/2/2023 (Initial admitted), indicated Resident 3 was at Risk for Respiratory Complications related to anxiety (fear of the unknown) and COPD. The Care Plan interventions did not have a specific goal, intervention on management of respiratory care and oxygen therapy. RN 3 stated there should have been a care plan because Resident 3 was receiving oxygen. RNS 3 stated the facility staff would not know if the resident was getting better or worse. During a concurrent interview and record review on 4/22/2025 at 4:07 PM of the facility's P&P titled Care Plan Comprehensive dated 8/25/2021, the P&P indicated An individualized comprehensive care plan included measurable and timetables to meet the resident's medical, physical, mental, and psychosocial needs should have been developed for each resident. The P&P indicated Assessments of resident were ongoing, and care plans were reviewed and revised as information about the resident and the resident's condition changed. The Interdisciplinary Team was responsible for evaluation and updating of care plans: when there had been a significant change in the resident's condition or when the desired outcome was not met. RNS 3 stated the facility staff were not following the Care Plan P&P because there were no goals or interventions to closely monitor the resident which could be detrimental to Resident 3's health. During a concurrent interview and record review on 4/22/2025 at 4:45 PM of Resident 3's Comprehensive Care Plan, the IDON stated there was no resident centered care plan for oxygen therapy so that the nurses could refer to when caring for the residents. The IDON stated the care plan should have been person-centered and if the care plan was not person-centered Resident 3 could have complications with her COPD, and she could suffer. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Oxygen Administration dated 4/2/2007, the P&P indicated The purpose of this procedure was to provide guidelines for safe oxygen administration. The P&P indicated Verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. 1b. During a review of Resident 3's Body Check dated 4/12/2025 at 9:37 PM indicated Resident 3 had no skin breakdown. 1b. During an observation on 4/22/2025 at 9:07 AM in Resident 3's room, Resident 3 was observed with reddish/purplish discoloration/hematoma to her right trunk area while two facility staff were providing incontinent care to Resident 3. Resident 3 did not appear to be in pain and when a facility staff asked the resident if she was in pain, Resident 3 replied with no. During a review of Resident 3's comprehensive Care Plans the Care Plan did not have documentation regarding the resident having a palm size reddish/purplish discoloration/hematoma to the right rib/trunk of the body (the main part, everything from the neck down to the waist, excluding the arms and legs). The care plan did not include the goals or interventions for the management hematoma and skin discoloration. During an interview on 4/23/2025 at 9:31 AM, the Treatment Nurse (TXN) 5 stated Resident 3 had the right trunk discoloration upon readmission to the facility but did not develop a care plan or implemented interventions for the management of skin discoloration. During a concurrent interview and concurrent record review with the IDON on 4/23/2025 at 9:45 AM, indicated Resident 3's Body Check on 4/12/2025 timed at 9:37 PM and Resident 3's Readmission Skin Assessment on 4/13/2025 timed at 12:58 PM. The IDON stated the two documents had conflicting information. The Body Check indicated Resident 3 had no skin issues whereas the Readmission Skin Assessment indicated the resident had five different skin issues. The IDON stated the two documents had conflicting information and should not have been like that. During a concurrent interview and record review of Resident 3's Comprehensive Care Plan on 4/23/2025 at 10 AM, the IDON stated the resident did not have a care plan for the management of reddish/purplish discoloration/hematoma to her right trunk area. The IDON stated Resident 3 should have had a care plan so the wound could be monitored otherwise Resident 3 could have further complications and developed pain related to the area or have other skin issues. The IDON stated there was no continued assessment or reassessment of Resident 3's reddish/purplish discoloration/hematoma to her right trunk area but there should have been. The IDON stated the facility was not following the P&P because Resident 3 should have had a care plan for the reddish/purplish discoloration/hematoma to her right trunk area. The IDON stated that without a care plan, the resident could have further complications, skin issues, pain, and if the facility was not reassessing the wound, the facility staff would not know if the wound was getting better or not. 44636 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting left non-dominant side, functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), and urinary tract infection (UTI, an infection of the bladder and urinary system). During a record review of Resident 1's care plan, revised 4/14/2023, the care plan indicated Resident 1 was at risk for skin breakdown related to advanced age (greater than [AGE] years), decreased activity, frail fragile skin, history of pressure ulcer, impaired cognition (mental action or process of acquiring knowledge and understanding), incontinence (involuntary loss of urine or stool), limited mobility, and diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin [a hormone released from the pancreas that controls the amount of glucose in the blood], causing blood sugar [glucose] levels to be abnormally high). The staff interventions were to turn and/or reposition the resident as needed to resident comfort, observe skin for signs/symptoms of skin breakdown, and observe skin condition daily with activities of daily living care and report abnormalities. During a record review of Resident 1's care plan, revised 9/25/2024, the care plan indicated Resident 1 had scattered discoloration to the right and left upper extremities. The staff interventions indicated the facility will assist the resident in turning and repositioning every 2 hours and provide wound treatment as ordered. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 1/31/2025, the MDS indicated the resident had severe cognitive impairment for daily decision making. The MDS indicated Resident 1 had impairment to both sides of the upper extremities (shoulders, elbows, wrists, hands) and lower extremities (hips, knees, ankles, feet). The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, upper and lower body dressing, rolling left and right, and sitting to lying. The MDS also indicated Resident 1 had Stage 3 Pressure injury (full thickness tissue loss where the skin and underlying subcutaneous fat are damaged, but the bone, tendon, or muscle is not exposed). During a record review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 2/17/2025, indicated Resident 1 was at high risk for developing pressure injury. During a record review of Resident 1's Physician Order Summary Report, dated 4/9/2025, the order indicated MASD to perineal area extend to groin area, cleanse with normal saline, pat dry, apply barrier cream, leave open to air everyday shift for 30 days. During a record review of Resident 1's Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident), dated 4/9/2025, the IDT care conference indicated Resident 1 had a Stage 3 pressure injury on the sacrococcyx measuring 3. 0-centimeter (cm, unit of measurement) x 3.0 cm x 0.4 cm. The IDT also indicated Resident 1 had MASD to the perineal area extending to the groin. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Wound Assessment, dated 4/9/2025, the assessment indicated Resident 1's Stage 3 pressure injury had reopened on the sacrococcyx and measured 3.0 cm x 3.0 cm x 0.4 cm with wound bed 90 % pink and 10 % slough with the wound margines and peri-wound (area of skin surrounding the wound) and macerated (skin that has softened and broken down due to prolonged exposure to moisture), atrophic (thinning and weakening of the skin), slough (a layer of dead, yellow-white tissue that forms in a wound), and friable (breaking easily). The assessment also indicated 100% MASD on the perineal area with wound margins and peri-wound was macerated and friable. The assessment indicated that due to wound history, Resident 1 was at high risk for wound reopening, wound decline, and delayed wound healing. During an observation on 4/21/2025 at 8:59 AM in Resident 1's room, Resident 1 was sleeping and lying on his back. During an interview on 4/21/2025 at 10:03 AM with CNA 1, CNA 1 stated she changed Resident 1 around 8 AM in the morning. CNA 1 stated the next change was going to be around 2 PM. CNA 1 stated she would not change Resident 1 prior to 2 PM because she had to take care of the other residents and had to do tasks like passing out the food trays. During an observation on 4/21/2025 at 10:06 AM in Resident 1's room, Resident 1 was lying in LAL mattress and sleeping on his back and was not repositioned. During an observation on 4/21/2025 at 11:30 AM in Resident 1's room, Resident 1 was in LAL mattress and sleeping on his back and was not repositioned. During an observation on 4/21/2025 at 2 PM in Resident 1's room, Resident 1 was in bed awake lying on his back and was not repositioned. During an interview on 4/21/2025 at 2:02 PM with CNA 1, CNA 1 stated she had not changed and reposition Resident 1 since this morning at around 8 AM. During an interview on 4/21/2025 at 2:16 PM with CNA 1, CNA 1 stated CNA 1 and TXN 2 would usually do the brief and dressing change at this time (2 PM). CNA 1 stated she was not able to locate TXN 2. During an observation on 4/21/2025 at 2:40 PM in Resident 1's room, Resident 1 was awake and lying on his back. During an observation on 4/21/2025 at 2:47 PM in Resident 1's room, CNA 1 and CNA 2 repositioned and changed Resident 1's brief. MDSN/TXN changed the pressure injury dressing and provided treatment to the MASD on the perineal area. During an interview on 4/21/2025 at 3:10 PM with CNA 2, CNA 2 stated it was the first time going inside Resident 1's room today to help with the brief change and positioning. CNA 2 stated prior to Resident 1's brief change and treatment, Resident 1 was lying on his back. CNA 2 stated nursing staff were supposed to check for incontinence every 2 hours and reposition the residents every 2 hours. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2025 at 9:55 AM with TXN 3, TNX 3 stated Resident 1 had a reopened Stage 3 pressure injury on the sacrococcyx and MASD on the perineal area. TXN 3 stated the interventions for Resident 1's pressure injury was placing the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure sores designed to circulate a constant flow of air for the management of pressure sores), turning and repositioning every 2 hours, and offloading of the heels. TXN 3 stated Resident 1 should not be positioned on his back for greater than 2 hours to prevent pressure on his bony prominences especially on his back since the goal was trying to relieve pressure off Resident 1's back. TXN 3 stated Resident 1's pressure injury could get worse and increase in size if Resident 1 were to stay lying too long on his back. TXN 3 stated Resident 1 did not have a behavior to refuse to be turned and repositioned. During the same interview on 4/22/2025 at 9:55 AM with TXN 3, TNX 3 stated Resident 1 should be checked for incontinence at least every hour since he had a lot of bowel movements. TXN 3 stated Resident 1's skin was very fragile and sensitive and could burn and macerate his skin if he was not being changed for his incontinence. TXN 3 stated MASD developed from not being changed or from sweating. TNX 3 stated Resident 1 was at severe risk for developing pressure ulcers. TXN 3 stated Resident 1 required two people to change and reposition him. During an interview on 4/23/2025 at 8:58 PM with MDSN 1, MDSN 1 stated Resident 1 returned to the facility on [DATE]. MDSN 1 stated the longer the moisture stays in the resident's perinium the more the MASD would get worse. MDSN 1 stated residents were checked every 2 hours for incontinent care and repositioned every 2 hours and as needed for their comfort. MDSN 1 stated to prevent skin breakdown the residents were supposed to be kept dry, clean, skin care provided, and turning and repositioning. MDSN 1 stated when incontinent residents were not changed, the residents could develop skin breakdown and MASD could worsen and cause skin irritation and discomfort to the residents. During a concurrent interview and record review on 4/23/2025 at 9:10 AM with MDSN 1 of Resident 1's care plans, MDSN 1 stated Resident 1's care plan did include interventions to check the residents for incontinence care every 2 hours and as needed, which the nurses were supposed to be doing. MDSN 1 stated Resident 1 developed a new MASD when he was readmitted on [DATE] to the facility. MDSN 1 stated the licensed nurse was supposed to create an individualized care plan to address Resident 1's care and treatment for the MASD and meet the goal to resolve the MASD. MDSN 1 stated an intervention for the MASD should include incontinent interventions to make sure the resident was being changed every 2 hours. During an interview on 4/23/2025 at 10:05 AM with the Interim Director of Nursing (IDON), the IDON stated nurses were supposed to provide good skin care, turn and reposition every 2 hours, and check the residents every 2 hours for incontinence to prevent skin breakdown. The IDON stated these interventions were done to prevent further skin breakdown for incontinence and pressure injury. The IDON stated residents should not have to wait over six (6) hours or later to be repositioned and/or changed. The IDON stated the residents needed to be repositioned and/or changed every 2 hours which was the standard of practice. The IDON also stated Resident 1 should have a care plan for MASD to address the problem and the care plan would allow the nurses to know the care plan and how to care for the residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's P&P titled, Skin Integrity Management, dated 5/26/2021, the P&P indicated to provide safe and effective care to prevent occurrence of pressure ulcers, management treatment, and promote healing of all wounds. The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observe and monitor patients for changes and implement revisions to the care plan as needed. Turning and repositioning based on resident care needs. During a review of the facility's policy and procedure (P&P) titled Care Plan Comprehensive dated 8/25/2021 with the IDON, the P&P indicated an individualized comprehensive care plan included measurable and timetables to meet the resident's medical, physical, mental, and psychosocial needs should be developed for each resident, designed to incorporate identified problem areas, interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to provide care and services for prevention and management of skin breakdown in accordance with the resident's care plan, standard of practice, care plan and facility's policy for two of two sampled residents (Resident 1 and 3) who were at risk for skin breakdown by failing to ensure: 1a. Resident 1 was checked for incontinence (involuntary loss control of urination or bowel movement) and changed as needed due to moisture associated skin damage (MASD- caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus) upon re-admission to the facility. 1b. Resident 1 with Stage 3 Pressure injury (full thickness tissue loss where the skin and underlying subcutaneous fat are damaged, but the bone, tendon, or muscle is not exposed) was turned and repositioned as needed and/or every two hours. 2. Resident 3's was assessed, documented and implemented interventions for the reddish/purplish discoloration/hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) to her right trunk area upon readmission to the facility from the General Acute Care Hospital (GACH) on 4/12/2025. These deficient practices had the potential to place Resident 1 at risk for skin integrity complications and to have worsening MASD and pressure ulcer (an injury that breaks down the skin and underlying tissue) such as pain, discomfort and infection. For Resident 3 the failure could result in not receiving appropriate and timely care for the skin discoloration and hematoma that could lead to pain, discomfort and increased bleeding that is not monitored. Findings: 1a. During a record review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area) affecting left non-dominant side, functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), and urinary tract infection (UTI, an infection of the bladder and urinary system). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's care plan, revised 4/14/2023, the care plan indicated Resident 1 was at risk for skin breakdown related to advanced age (greater than [AGE] years), decreased activity, frail fragile skin, history of pressure ulcer, impaired cognition (mental action or process of acquiring knowledge and understanding), incontinence (involuntary loss of urine or stool), limited mobility, and diabetes mellites (a disorder in which the body does not produce enough or respond normally to insulin [a hormone released from the pancreas that controls the amount of glucose in the blood], causing blood sugar [glucose] levels to be abnormally high). The staff interventions were to turn and/or reposition the resident as needed to resident comfort, observe skin for signs/symptoms of skin breakdown, and observe skin condition daily with activities of daily living care and report abnormalities. During a record review of Resident 1's care plan, revised 9/25/2024, the care plan indicated Resident 1 had scattered discoloration to the right and left upper extremities. The staff interventions were to assist the residents in turning and repositioning every 2 hours and provide wound treatment as ordered. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 1/31/2025, the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 1 had impairment to both sides of the upper extremities (shoulders, elbows, wrists, hands) and lower extremities (hips, knees, ankles, feet). The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, upper and lower body dressing, rolling left and right, and sitting to lying. The MDS also indicated Resident 1 had a Stage 3 Pressure injury (full thickness tissue loss where the skin and underlying subcutaneous fat are damaged, but the bone, tendon, or muscle is not exposed). During a record review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 2/17/2025, the Braden Scale indicated Resident 1 was at severe risk for developing pressure injury. During a record review of Resident 1's Physician Order Summary Report, dated 4/9/2025, the order indicated MASD to perineal area extend to groin area, cleanse with normal saline, pat dry, apply barrier cream, leave open to air everyday shift for 30 days. During a record review of Resident 1's Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident), dated 4/9/2025, the IDT care conference indicated Resident 1 had a Stage 3 pressure injury on the sacrococcyx measuring 3. 0-centimeter (cm, unit of measurement) x 3.0 cm x 0.4 cm. The IDT also indicated Resident 1 had MASD to the perineal area extending to the groin. During a record review of Resident 1's Wound Assessment, dated 4/9/2025, the assessment indicated Resident 1's Stage 3 pressure injury had reopened on the sacrococcyx and measured 3.0 cm x 3.0 cm x 0.4 cm with wound bed 90 % pink and 10 % slough with the wound margines and peri-wound (area of skin surrounding the wound) and macerated (skin that has softened and broken down due to prolonged exposure to moisture), atrophic (thinning and weakening of the skin), slough (a layer of dead, yellow-white tissue that forms in a wound), and friable (breaking easily). The assessment also indicated 100% MASD on the perineal area with wound margins and peri-wound was macerated and friable. The assessment indicated that due to wound history, Resident 1 was at high risk for wound reopening, wound decline, and delayed wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/21/2025 at 8:59 AM in Resident 1's room, Resident 1 was sleeping and lying on his back. During an interview on 4/21/2025 at 9:25 AM with Treatment Nurse 2 (TXN 2), TXN 2 stated she just spoke with Certified Nursing Assistant 1 (CNA 1) and TXN 2 would change Resident 1's pressure injury dressing at 2 PM during Resident 1's next brief (protective underwear to prevent leakage) change. TXN 2 stated CNA 1 had already changed his brief this morning and preferred to do the dressing change along with the brief change scheduled at 2 PM. During an interview on 4/21/2025 at 10:03 AM with CNA 1, CNA 1 stated she changed Resident 1 around 8 AM in the morning. CNA 1 stated the next change was going to be around 2 PM. CNA 1 stated at 2 PM, CNA 1 and TXN 2 were going to do everything all together (brief and dressing change). CNA 1 stated she would not change Resident 1 prior to 2 PM because she had to take care of the other residents and had to do tasks like passing out the food trays. During an observation on 4/21/2025 at 10:06 AM in Resident 1's room, Resident 1 was lying in bed and sleeping on his back and was not repositioned. During an observation on 4/21/2025 at 11:30 AM in Resident 1's room, Resident 1 was lying in bed and sleeping on his back and was not repositioned. During an observation on 4/21/2025 at 2 PM in Resident 1's room, Resident 1 was in bed awake lying on his back and was not repositioned. During an interview on 4/21/2025 at 2:02 PM with CNA 1, CNA 1 stated she had not changed and reposition Resident 1 since this morning at around 8 AM. CNA 1 stated she will try to find TXN 2 to assist her. During an interview on 4/21/2025 at 2:16 PM with CNA 1, CNA 1 stated CNA 1 and TXN 2 would usually do the brief and dressing change at this time (2 PM). CNA 1 stated she was not able to locate TXN 2. During an interview on 4/21/2025 at 2:34 PM with Minimum Data Set Nurse/Treatment Nurse (MDSN/TXN), MDSN/TXN stated she did not know what happened to TXN 2 and will be changing Resident 1's pressure injury dressing. During an observation on 4/21/2025 at 2:40 PM in Resident 1's room, Resident 1 was awake and lying on his back. During an observation on 4/21/2025 at 2:47 PM in Resident 1's room, CNA 1 and CNA 2 repositioned and changed Resident 1's brief. MDSN/TXN changed the pressure injury dressing and provided treatment to the MASD on the perineal area. During an observation on 4/21/2025 at 2:54 PM in Resident 1's room, CNA 1 and CNA 2 repositioned Resident 1 on the right-hand side facing the window. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/21/2025 at 2:58 PM with CNA 1, CNA 1 stated when TXN 2 came in this morning CNA 1 had informed her that CNA 1 had already changed Resident 1. CNA 1 stated TXN 2 wanted to know when CNA 1 was going to do her next round of brief changes. CNA 1 stated she informed TXN 2 around 2 PM, but did not know what happened to TNX 2 at 2 PM. CNA 1 stated residents were repositioned every 2 hours. CNA 1 stated she repositioned Resident 1 twice this morning with CNA 2 prior to changing his brief (2:47 PM). During an interview on 4/21/2025 at 3:10 PM with CNA 2, CNA 2 stated she did not help CNA 1 reposition Resident 1 prior to the brief change that just occurred (2:47 PM). CNA 2 stated it was the first time going inside Resident 1's room today to help with the brief change and positioning for Resident 1's treatment to be done by the treatment nurse. CNA 2 stated prior to Resident 1's brief change and treatment, Resident 1 was lying on his back. CNA 2 stated nursing staff were supposed to check for incontinence every 2 hours and reposition the residents every 2 hours. During an interview on 4/22/2025 at 9:55 AM with TXN 3, TNX 3 stated Resident 1 had a reopened Stage 3 pressure injury on the sacrococcyx and MASD on the perineal area. TXN 3 stated the interventions for Resident 1's pressure injury was placing the low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure sores designed to circulate a constant flow of air for the management of pressure sores), turning and repositioning every 2 hours, and offloading of the heels. TXN 3 stated Resident 1 should not be positioned on his back for greater than 2 hours to prevent pressure on his bony prominences especially on his back since the goal was trying to relieve pressure off Resident 1's back. TXN 3 stated Resident 1's pressure injury could get worse and increase in size if Resident 1 were to stay lying too long on his back. TXN 3 stated Resident 1 did not have a behavior to refuse to be turned and repositioned. During the same interview on 4/22/2025 at 9:55 AM with TXN 3, TNX 3 stated Resident 1 should be checked for incontinence at least every hour since he had a lot of bowel movements. TXN 3 stated Resident 1's skin was very fragile and sensitive and could burn and macerate his skin if he was not being changed for his incontinence. TXN 3 stated MASD developed from not being changed or from sweating. TNX 3 stated Resident 1 was at severe risk for developing pressure ulcers. TXN 3 stated Resident 1 required two people to change and reposition him. During an interview on 4/23/2025 at 8:58 PM with MDSN 1, MDSN 1 stated Resident 1 returned to the facility on [DATE]. MDSN 1 stated the longer the moisture stays in the resident's perinium the more the MASD would get worse. MDSN 1 stated residents were checked every 2 hours for incontinent care and repositioned every 2 hours and as needed for their comfort. MDSN 1 stated to prevent skin breakdown the residents were supposed to be kept dry, clean, skin care provided, and turning and repositioning. MDSN 1 stated when incontinent residents were not changed, the residents could develop skin breakdown and MASD could worsen and cause skin irritation and discomfort to the residents. During a concurrent interview and record review on 4/23/2025 at 9:10 AM with MDSN 1 of Resident 1's care plans, MDSN 1 stated Resident 1's care plan did include interventions to check the residents for incontinence care every 2 hours and as needed, which the nurses were supposed to be doing. MDSN 1 stated Resident 1 developed a new MASD when he was readmitted on [DATE] to the facility. MDSN 1 stated the licensed nurse was supposed to create an individualized care plan to address Resident 1's care and treatment for the MASD and meet the goal to resolve the MASD. MDSN 1 stated an intervention for the MASD should include incontinent interventions to make sure the resident was being changed every 2 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 10:05 AM with the Interim Director of Nursing (IDON), the IDON stated nurses were supposed to provide good skin care, turn and reposition every 2 hours, and check the residents every 2 hours for incontinence to prevent skin breakdown. The IDON stated these interventions were done to prevent further skin breakdown for incontinence and pressure injury. The IDON stated residents should not have to wait over six (6) hours or later to be repositioned and/or changed. The IDON stated the residents needed to be repositioned and/or changed every 2 hours which was the standard of practice. The IDON also stated Resident 1 should have a care plan for MASD to address the problem and the care plan would allow the nurses to know the care plan and how to care for the residents. During a record review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated appropriate care and services will be provided for residents who are unable to care out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting). During a record review of the facility's P&P titled, Certified Nursing Assistant, revised 10/2020, the P&P indicated CNAs will assist residents in accordance with their needs ranging from minimal assistance total dependent care on ADLs. CNAs will contribute to the development and implementation of interventions in accordance with the residents' needs/goals for care preferences and recognize standards of practice that address the identified limitations in ability to perform ADLs. During a record review of the facility's P&P titled, Skin Integrity Management, dated 5/26/2021, the P&P indicated to provide safe and effective care to prevent occurrence of pressure ulcers, management treatment, and promote healing of all wounds. The implementation of an individual patient's kin integrity management occurs within the care delivery process. Staff continually observe and monitor patients for changes and implement revisions to the care plan as needed. Turning and repositioning based on resident care needs. During a record review of the facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. Each resident's comprehensive care plan is designed to incorporate identified problem areas. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. 48661 2. During a review of Resident 3 ' s Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included morbid obesity (a severe form of obesity where a person ' s Body Mass Index [BMI, a number calculated from your height and weight that was used to classify people as underweight, healthy weight, overweight, or obese] was 40 or higher), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's MDS dated [DATE], it indicated the resident ' s cognition (thought process and ability to reason) was intact. The MDS indicated Resident 3 required substantial/maximal assistance (helper did more than half the effort) from facility staff for chair/bed-to-chair transfer. The MDS indicated the residents did not have any falls since admission. During a review of Resident 3 ' s Body Check dated 4/12/2025 at 9:37 PM, indicated Resident 3 ' s had no skin issues. During an observation on 4/22/2025 at 9:07 AM in Resident 3 ' s room, Resident 3 was observed with reddish/purplish discoloration/hematoma to her right trunk area while two facility staff were providing incontinent care to Resident 3. Resident 3 did not appear to be in pain and when a facility staff asked the resident if she was in pain, Resident 3 replied with no. During a review of Resident 3 ' s comprehensive Care Plans the Care Plan did not have documentation regarding the resident having a palm size reddish/purplish discoloration/hematoma to the right rib/trunk of the body (the main part, everything from the neck down to the waist, excluding the arms and legs). The care plan did not include the goals or interventions for the management hematoma and skin discoloration. During an interview on 4/23/2025 at 9:31 AM, the Treatment Nurse (TXN) 5 stated Resident 3 had the right trunk discoloration upon readmission to the facility but did not develop a care plan or implemented interventions for the management of skin discoloration. During a concurrent interview and concurrent record review with the IDON on 4/23/2025 at 9:45 AM, indicated Resident 3 ' s Body Check on 4/12/2025 timed at 9:37 PM and Resident 3 ' s Readmission Skin Assessment on 4/13/2025 timed at 12:58 PM. The IDON stated the two documents had conflicting information. The Body Check indicated Resident 3 had no skin issues whereas the Readmission Skin Assessment indicated the resident had five different skin issues. The IDON stated the two documents had conflicting information and should not have been like that. During a concurrent interview and record review of Resident 3's Comprehensive Care Plan on 4/23/2025 at 10 AM, the IDON stated the resident did not have a care plan for the management of reddish/purplish discoloration/hematoma to her right trunk area. The IDON stated Resident 3 should have had a care plan so the wound could be monitored otherwise Resident 3 could have further complications and developed pain related to the area or have other skin issues. The IDON stated there was no continued assessment or reassessment of Resident 3 ' s reddish/purplish discoloration/hematoma to her right trunk area but there should have been. The IDON stated the facility was not following the P&P because Resident 3 should have had a care plan for the reddish/purplish discoloration/hematoma to her right trunk area. The IDON stated that without a care plan, the resident could have further complications, skin issues, pain, and if the facility was not reassessing the wound, the facility staff would not know if the wound was getting better or not. During a record review of the facility ' s P&P titled, Skin Integrity Management, dated 5/26/2021, the P&P indicated to provide safe and effective care to prevent occurrence of pressure ulcers, management treatment, and promote healing of all wounds. The implementation of an individual patient ' s kin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the care plan as needed. Turning and repositioning based on resident care needs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Care Plan Comprehensive dated 8/25/2021 with the IDON, the P&P indicated an individualized comprehensive care plan included measurable and timetables to meet the resident ' s medical, physical, mental, and psychosocial needs should be developed for each resident, designed to incorporate identified problem areas, interventions were designed after careful consideration of the relationship between the resident ' s problem areas and their causes

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48661 Based on observation, interview, and record review, the facility failed to prevent accident and hazard as indicated in the facility's policy and care plan by ensuring the wheelchair was properly locked to prevent accidental fall and ensure the resident was assessed for pain and injury after a fall of one of three sampled residents (Resident 3). As a result of this deficient practice Resident 3 had a fall without major injury but the deficient practice had the potential to result in the resident to have major injury or delayed and/or no care and treatment after the fall. Findings: During a review of Resident 3 ' s Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included morbid obesity (a severe form of obesity where a person ' s Body Mass Index [BMI, a number calculated from your height and weight that was used to classify people as underweight, healthy weight, overweight, or obese] was 40 or higher), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. During a review of Resident 3 ' s Risk for Falls Care Plan dated 3/23/2025, the Care Plan indicated a goal for the resident to be free of falls, free of minor injury, and the resident would not sustain serious injury. The Care Plan indicated interventions to ensure the resident ' s call light was within reach, to anticipate and meet the resident ' s needs, and to follow the facility fall protocol. During a review of Resident 3 ' s Nursing Evaluation dated 3/23/2025 at 1:34 PM, the Nursing Evaluation indicated the resident ' s Fall Risk Factor was due to impaired balance. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated the resident ' s cognition was intact. The MDS indicated Resident 3 required substantial/maximal assistance (helper did more than half the effort) from facility staff for chair/bed-to-chair transfer. The MDS indicated Resident 3 did not have any falls since admission. During a review of Resident 3 ' s medical records indicated no documented evidence that indicate the resident had a fall on 4/19/2025. During an interview on 4/22/2025 at 9:39 AM, Resident 3 stated facility staff did not put on socks for the resident or put on the brakes for the wheelchair and the resident fell on the floor. During the interview, Resident 3 started crying and did not want to discuss the incident further. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2025 at 9:55 AM, CNA 7 stated on 4/19/2025 he was called by CNA 6 because Resident 3 was on the floor, sitting up in front of the wheelchair. CNA 7 stated CNA 6 went to tell the LVN 7 about the incident because the CNAs were not supposed to move residents after a fall until the LVNs did an assessment. CNA 7 stated when CNA 6 came back from speaking with LVN 7, LVN 7 informed her (CNA 6) it was okay and to get the resident up. CNA 7 stated CNA 6 asked the resident if she (Resident 3) was in pain and when the resident said no, CNA 7 and CNA 6 placed Resident 3 back into bed. CNA 7 stated LVN 7 did not assess Resident 3 prior to them moving the resident. During an interview on 4/22/2025 at 11:50 AM, CNA 6 stated Resident 3 fell on [DATE] in her (Resident 3) room during a resident transfer from the bed to a wheelchair. CNA 6 stated Resident 3 was wearing skid free socks, but she did not know the brakes were not working properly before transferring Resident 3. CNA 6 stated the resident ' s butt was on the edge of the chair, and because the wheelchair ' s brakes were not locked properly, the wheelchair moved backward, and Resident 3 slipped on to the floor. CNA 6 stated CNA 7 walked by and provided assistance. During the same interview on 4/22/2025 at 11:50 AM, CNA 6 stated while CNA 7 stayed with Resident 3, she went to LVN 7 to report Resident 3 ' s fall incident. CNA 6 stated when she approached LVN 7, LVN 7 she would do a Change of Condition (COC) report. CNA 6 stated LVN 7 did not assess Resident 3 after the fall and instead directed CNA 6 to put the resident back into bed. CNA 6 stated LVN 7 should have assessed Resident 3 after the fall for the safety of the resident otherwise Resident 3 could have been more hurt or had more injuries. During an interview on 4/22/2025 at 2:09 PM, LVN 7 stated she was not aware of Resident 3 ' s fall incident therefore she did not develop a COC report or a care plan. LVN 7 stated on 4/19/2025, she did not recall Resident 3 falling or any facility staff informing her of a fall for Resident 3. During an interview on 4/22/2025 at 6:43 PM, the Interim Director of Nursing (IDON) stated she and Administrator (ADM) and licensed staffs were unaware of Resident 3 ' s fall on 4/19/2025 and started an investigation today in regard to the fall. The IDON stated for Resident 3 ' s fall incident there should have been an investigation and COC initiated at the time of the fall, the physician and resident ' s family should have been notified and there should have been an investigation. The IDON stated if the necessary steps were not done the resident could develop complications such as pain or skin issues related to the fall. During a review of the facility ' s P&P titled Falls - Clinical Protocol dated March 2018, the P&P indicated the staff would evaluate and document falls that occurred while the individual was in the facility; for example, when and where they happen and any observations of the events.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services in accordance with the facility's policy and procedures and standards of practice for one of three sampled residents (Resident 3) with COPD (Chronic Obstructive Pulmonary Disease- a progressive lung disease that causes shortness of breath and difficulty breathing), congestive heart failure (CHF, a heart disorder which caused the heart to not pump the blood efficiently causing shortness of breath) by failing to: 1. Indicate the justification for the use of Resident 3's oxygen therapy. 2. Ensure physician's order for prn (as needed) oxygen therapy outlines oxygen parameters to determine the appropriate level of supplemental oxygen to be delivered to Resident 3. 3. Develop and implement a comprehensive and resident centered care plan for Resident 3 with chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing)/oxygen (O2) therapy. These deficient practices had the potential to result in Resident 3 to receive too much or not sufficient oxygen therapy and have increased difficulty breathing and shortness of breath and will result in inability to recognize if oxygen used by Resident 3 was required and effective. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included COPD cand CHF. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/6/2025, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 3's active diagnoses included heart failure and COPD. The MDS indicated the Resident 3 did not have shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. The MDS indicated the Resident 3 did not have any respiratory treatments including oxygen (O2) therapy. During a review of Resident 3's MAR (Medication Administration Record) indicated Resident 3 had no documented evidence Resident 3 received oxygen as needed from 4/17/2025 to 4/22/2025. During a review of Resident 3's Order Summary (a physician's order) dated 4/17/2025 at 1:32 PM, the Order Summary indicated to deliver oxygen at two liters per minute (2L/min, a way to measure the rate of flowing oxygen) via nasal cannula (NC, a medical device, a simple way to deliver supplemental oxygen) as needed for COPD. The Order Summary did not indicate parameters on what oxygen blood level or when to increase or decrease the oxygen therapy. (continued on next page)

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	056487	A. Building B. Wing	04/23/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident required oxygen on but did not indicate the amount of oxygen delivered: 1. 4/17/2025 at 12:02 AM, oxygen saturation: 97% (Oxygen via NC). 2. 4/20/2025 at 12:10 AM, oxygen saturation: 97% (Oxygen via NC). 3. 4/20/2025 at 11:26 PM, oxygen saturation: 99% (Oxygen via NC). 4. 4/21/2025 at 12:27 AM, oxygen saturation: 98% (Oxygen via NC). 5. 4/22/2025 at 12 AM, oxygen saturation: 98% (Oxygen via NC). During a concurrent interview and record review of Resident 3's April MAR on 4/21/2025 at 4:18 PM, LVN 6 stated the MAR did not indicate Resident 3 received oxygen therapy, the Progress Notes did not indicate when Resident 3 was placed on oxygen, the reason for the oxygen, how long the resident was on oxygen for, and when or why the oxygen was discontinued. The Progress Notes did not have documented evidence that indicated the physician was notified why Resident 3 was placed on oxygen uses from 4/17/2025 to 4/22/2025, a total of five times the resident required oxygen. During a concurrent interview and record review of Resident 3's Progress Notes on 4/21/2025 at 4:19 PM, LVN 6 stated the resident's Progress Notes did not indicate the resident received oxygen. LVN 6 stated there should have been documentation Resident 3 received oxygen because that could affect the resident's safety, and the resident could decline. During an observation on 4/22/2025 at 7:51 AM in Resident 3's room, Resident 3 was sleeping in bed with the head of bed elevated at45 degrees angle receiving oxygen via NC at 2L/min. During a concurrent interview and record review of Resident 3's Order Summary report, dated 4/17/2025 at 1:32 PM on 4/22/2025 at 3:43 PM, the Registered Nurse Supervisor (RNS) 3 stated the physician order should have had a reason for the oxygen use and the parameter on when to start and stop the oxygen therapy. RNS 3 stated the order must be clarified and there should have been documentation when the resident was placed on oxygen, the resident's response to the oxygen, and an assessment to see if Resident 3 was tolerating the oxygen and to monitor if titration (the process of adjusting the amount of oxygen a patient received to maintain an adequate level of oxygen in their blood, typically between 94-98% saturation) was needed. RNS 3 stated there was no documented evidence that Resident 3 was assessed for oxygen use. During a concurrent interview and record review of Resident 3's Medical Record on 4/22/2025 at 3:50 PM, RNS 3 stated there was no documented evidence that the physician was made aware of the resident's need for oxygen. RNS 3 stated the physician should have been notified to monitor if the resident could be taken off the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 3's Comprehensive Care Plan on 4/22/2025 at 3:55 PM, RNS 3 stated Resident 3's Care Plan, dated 11/2/2023 (Initial admitted), indicated Resident 3 was at Risk for Respiratory Complications related to anxiety (fear of the unknown) and COPD. The Care Plan interventions did not have a specific goal, intervention on management of respiratory care and oxygen therapy. RN 3 stated there should have been a care plan because Resident 3 was receiving oxygen. RNS 3 stated the facility staff would not know if the resident was getting better or worse. During a concurrent interview and record review on 4/22/2025 at 4:03 PM of the facility's policy and procedure (P&P) titled Chronic Obstructive Pulmonary Disease (COPD) - Clinical Protocol dated November 2018, the P&P indicated The staff and physician would monitor the progress of individuals with COPD, including ongoing evaluation and documentation of signs and symptoms and condition changes. The physician and staff would use screening tests such as pulse oximetry appropriately and in accordance with their known limitations. RNS 3 stated the facility staff were not following the COPD P&P because the facility staff were not closely monitoring the resident to see if she was getting better or worse and that could be detrimental because of Resident 3's oxygen, her (Resident 3) oxygen could drop and that would be dangerous. During a concurrent interview and record review on 4/22/2025 at 4:07 PM of the facility's P&P titled Care Plan Comprehensive dated 8/25/2021, the P&P indicated An individualized comprehensive care plan included measurable and timetables to meet the resident's medical, physical, mental, and psychosocial needs should have been developed for each resident. The P&P indicated Assessments of resident were ongoing, and care plans were reviewed and revised as information about the resident and the resident's condition changed. The Interdisciplinary Team was responsible for evaluation and updating of care plans: when there had been a significant change in the resident's condition or when the desired outcome was not met. RNS 3 stated the facility staff were not following the Care Plan P&P because there were no goals or interventions to closely monitor the resident which could be detrimental to Resident 3's health. During an interview on 4/22/2025 at 4:31 PM, the Interim Director of Nursing (IDON) stated there was no documented evidence for why Resident 3 required oxygen in the progress notes or the MAR. The IDON stated there should have been ongoing documentation of when and why the resident needed oxygen and the resident's response to using the oxygen. The IDON also stated the physician was not notified but should have been made aware because the resident needed oxygen almost every night. During a concurrent interview and record review on 4/22/2025 at 4:45 PM of Resident 3's Comprehensive Care Plan, the IDON stated there was no resident centered care plan for oxygen therapy so that the nurses could refer to when caring for the residents. The IDON stated the care plan should have been person centered and if the care plan was not person-centered Resident 3 could have complications with her COPD, and she could suffer. During a concurrent interview and record review on 4/22/2025 at 4:56 PM of the facility's P&P titled Chronic Obstructive Pulmonary Disease (COPD) - Clinical Protocol dated November 2018, the IDON stated the facility was not following the P&P and that could cause complications to Resident 3's COPD such as shortness of breath (SOB, the feeling of not getting enough air or having trouble breathing). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2025 at 8:25 AM, LVN 5 stated Resident 3 uses oxygen when lying down, otherwise the resident would complain of SOB. LVN 5 stated at the start of her shift, Resident 3 uses oxygen on every morning. LVN 5 stated when she administers oxygen to Resident 3, she documents when the oxygen was administered and not when it was discontinued. oxygen, she (LVN 5) would document when the oxygen was admin, but not when the oxygen was taken off. LVN 5 stated she should have documented when the oxygen was taken off to know how much oxygen Resident 3 required during the day. During a review of the facility's P&P titled Oxygen Administration dated 4/2/2007, the P&P indicated The purpose of this procedure was to provide guidelines for safe oxygen administration. The P&P indicated Verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to identify, assess, treat, and evaluate pain for one of two sampled residents (Resident 4), who showed signs of pain and verbalized severe pain to the left leg on 4/21/2025 at 9:22 PM and up to 2:10 PM the next day on 4/22/2025 (16 hours), in accordance with the facility ' s policy and procedure (P&P) titled Pain Management. As a result, Resident 4 verbalized hopelessness for experiencing horrific pain and sleeplessness on 4/21/2025 until the next day on 4/22/2025. This has the potential to result in Resident 4 ' s unmet needs and affect the resident ' s cognitive processes and significantly affect quality of life. Findings: During a review of Resident 4 ' s Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic pain syndrome (ongoing pain that lasted longer than expected, often for months or years, and could affect daily life), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee, sciatica (a condition characterized by pain that radiated along the sciatic nerve, which runs from the lower back through the buttocks and down the back of each leg) of the left side, lower end (distal) of left femur fracture (a break in the thigh bone near the knee joint), left tibia fracture (a break or crack in the tibia, which was the larger of the two bones in the lower leg), chronic ulcer (a break on the skin, in the lining of an organ, or on the surface of a tissue) of part of left lower leg, chronic ulcer of left calf, and left lower quadrant pain (pain felt in the lower left part of the abdomen). During a review of Resident 4 ' s previously submitted Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/3/2025, the MDS indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 4 ' s active diagnoses included chronic pain syndrome. The MDS indicated Resident 4 receives scheduled pain medication, had the presence of pain frequently in the last five days, and occasionally could not sleep because of the pain with a pain rating of seven (From a zero to ten scale, with zero being no pain and ten as the worst pain you could imagine). The MDS indicated Resident 4 had a Care Area Assessment (CAA) for pain. During a review of Resident 4 ' s Situation, Background, Assessment, and Recommendation (SBAR, a communication tool used by healthcare workers when there was a change of condition among the residents) dated 4/19/2025, the SBAR indicated Resident 4 complained of leg pain and received pain medication but still complained of leg pain and called 911 (emergency phone number to request help from emergency services like an ambulance when there was a serious situation) without informing the facility staff. The SBAR indicated the physician and resident ' s representative was made aware of Resident 4 ' s transfer to the General Acute Care Hospital (GACH) via 911 on 4/19/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4 ' s GACH Discharge (DC) Summary dated 4/20/2025, the GACH DC Summary indicated Resident 4 ' s Final Diagnoses included acute osteomyelitis, arthritis of the knee, chronic pain, urinary tract infection (UTI) due to Extended Spectrum Beta Lactamase (ESBL - an enzyme produced by bacteria that are resistant to a wide range of antibiotics). The GACH DC Summary indicated Resident 4 had a recent surgery to the left leg and was getting ready to be discharged back to the facility on [DATE]. During a review of Resident 4 ' s GACH Transfer/Discharge Medication Review & Order Sheet dated 4/21/2025, the Transfer/Discharge Medication Review & Order Sheet under the Active Orders as of 4/21/2025, indicated Resident 4 was receiving acetaminophen-hydrocodone (a combined medication preparation to treat moderate to severe pain) 325 milligram (mg, unit of measurement) - 10 mg oral tablet while at the GACH for severe pain with last dose administered to the resident on 4/21/2025 at 2:34 AM and was receiving acetaminophen-hydrocodone 325 mg - five mg oral tablet) for moderate pain with last dose received on 4/21/2025 at 10:21 AM. Resident 4 ' s GACH Discharge Medication List, however, did not include these pain medications for moderate and severe pain in the actual list under the GACH Discharge Medications. During a review of Resident 4 ' s Order Summary Report dated 4/21/2025, the Order Summary Report indicated to document the resident ' s pain level with a pain rating scale of 1 to 4 as mild pain, 5 to 7 as moderate pain, and 8 to 10 as severe pain, every shift. The Order Summary Report indicated a physician order for acetaminophen 325 mg, insert two suppository rectally every six hours as needed for mild pain. During a review of Resident 4 ' s Nursing Progress Note dated 4/21/2025, the Nursing Progress Note indicated Resident4 was readmitted from the GACH with a discharge diagnosis of bacterial urinary tract infection (UTI, an infection in the bladder/urinary tract). The Nursing Progress Note indicated the Registered Nurse Supervisor (RNS) 4 reconciled medications with the physician and faxed the orders to the pharmacy. During a review of Resident 4 ' s assessment dated [DATE] at 9:22 PM, the Assessment indicated the resident had no complaint of pain. During a review of Resident 4 ' s care plan for Acute Pain related to acute osteomyelitis (an infection of the bone tissue) dated 4/22/2025, the care plan indicated a goal for the resident to verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The care plan interventions included to anticipate the resident ' s need for pain relief and respond immediately to any complaint of pain, notify physician if interventions were unsuccessful, and to report any change in usual activity attendance patterns and complaints of pain or discomfort. During a concurrent observation and interview on 4/22/2025 at 10:55 AM in Resident 4 ' s room, Resident 4 stated she had a lot of pain on her left leg. Resident 4 stated she called the nurse earlier this morning, around 9:30 AM, but nobody came. Resident 4 pressed the call light for some water and CNA 8 responded at 11:02 AM. After 5 minutes, CNA 8 came back with water and Resident 4 informed CNA 8 about her leg pain. CNA 8 stated [LVN 8] would be checking her (Resident 4) pain medications. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same observation and interview on 4/22/2025 at 11:15 AM, in Resident 4 ' s room, Treatment Nurse (TXN) 4 entered Resident 4 ' s room to reapply Resident 4 ' s dressing to the left leg. TXN 4 stated she was just reapplying the dressing to the resident ' s left leg surgical wound. Resident 4 was observed guarding her left leg, with facial grimacing and making fists while verbalizing to TXN 4 to be careful, because her left leg really hurts, while TXN 4 was pulling Resident 4 ' s left sock. TXN 4 did not stop and continued to reapply the dressing to the left leg without assessing the resident ' s pain. TXN 4 was observed leaving the room after completing the resident ' s dressing change. Resident 4 was asked by the surveyor to describe her pain and Resident 4 stated her pain level at that time was 10 out of 10. Resident 4 stated she was given acetaminophen by the licensed nurse the night before (4/21/2025) but was still in pain. Resident 4 stated she had not received pain medication that morning (4/22/2025). During a subsequent observation and interview on 4/22/2025 at 11:20 AM in Resident 4 ' s room, LVN 8 entered the resident ' s room and informed Resident 4 that there was only acetaminophen (an over-the-counter analgesic [substance that reduces pain] drug used to treat mild pain) available for pain management. Resident 4 responded to LVN 4 and stated that the acetaminophen pain medication was not enough and LVN 8 responded to Resident 4 that acetaminophen was the only pain medication she had and left the room. After LVN 4 left the resident ' s room, Resident 4 stated I feel I ' m going to be laying with pain forever. They do not seem to understand. I have so much pain and it ' s their (facility staff) responsibility to take care of my need. During a subsequent interview on 4/22/2025 at 11:27 AM, LVN 8 was asked what pain medication was ordered by the physician for Resident 4 ' s chronic pain LVN 8 and stated Resident 4 did not have any other pain medications other than acetaminophen. LVN 8 stated when he started his shift that morning (4/22/2025), he did not ask Resident 4 ' s pain level. LVN 8 stated that he also did not assess Resident 4 ' s pain when he informed the resident that there was no other stronger pain medication available. LVN 8 stated he should have asked Resident 4 ' s pain level and pain description at that time. LVN 8 stated he would call the physician because Resident 4 stated acetaminophen did not relieve her pain. During a review of Resident 4 ' s Order Summary dated 4/22/2025 at 12:21 PM, the Order Summary indicated acetaminophen-codeine tablet 300-30mg, give two tablets every four hours as needed for severe pain. During a review of Resident 4 ' s Change of Condition (COC) Progress Note dated 4/22/2025 at 1:09 PM, the COC Progress Note indicated the physician was notified to discuss Resident 4 ' s pain management. The COC Progress Note indicated Tylenol #3 may be taken from the emergency kit (e-kit, a small collection of medications and supplies designed to be used in emergency situations, particularly when a pharmacy was not readily available). During an interview on 4/22/2025 at 1:50 PM, TXN 4 was asked why Resident 4 ' s pain was not assessed when TXN 4 was reapplying the left leg dressing change earlier that morning at 11:15 AM. TXN 4 stated she should have assessed Resident 4 ' s pain when she was reapplying the left leg dressing. TXN 4 acknowledged Resident 4 was making facial grimaces and making a fist and verbalized it hurts, while she was performing the dressing earlier at 11:15 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4 ' s MAR for April 2025, the MAR indicated Resident 4 received acetaminophen-codeine tablet 300-30 mg, two tablets by mouth for a pain level of seven (moderate pain) on 4/22/2025 at 2:10 PM. Further review of Resident 4 ' s MAR from 4/1/2025 to 4/30/2025, the MAR did not include or specify a pain medication prescribed for moderate pain level (5 to 7 level of pain). The MAR indicated Resident 4 ' s physician order for acetaminophen-codeine tablet 300-30 mg, two tablets by mouth every four hours was ordered for severe pain (8 to 10 level of pain). During a review of Resident 4 ' s Medication Administration Record (MAR) for April 2025, the MAR indicated that on 4/22/2025 for the 7 AM to 3 PM shift, Resident 4 had a pain level of seven (Pain level of 1 to 4 for mild pain, 5 to 7 for moderate pain, and 8 to 10 for severe pain). During another interview on 4/23/2025 at 2:45 PM, Resident 4 stated she was readmitted back to the facility from the GACH during the evening of 4/21/2025. Resident 4 stated when she was readmitted to the facility on [DATE], Resident 4 was in horrific pain. Resident 4 stated she received acetaminophen but informed the facility staff the acetaminophen was not working. Resident 4 stated she did not receive a stronger pain medication until the next day 4/22/2025. Resident 4 stated her pain level was a 10 out of 10 pain and the pain would shoot up and down her left side and she had a real bad headache. Resident 4 stated the pain was so bad she wanted to go back to the GACH. During an interview on 4/23/2025 at 4:39 PM, the Interim Director of Nursing (IDON) stated the facility assessed Resident 4 for pain on 4/21/2025 as documented in the MAR, but should have added the acetaminophen-codeine tablet pain medication to the resident ' s orders because that is what Resident 4 was receiving at the GACH. During a review of the facility ' s policy and procedure (P&P) titled Pain Management dated 8/25/2021, the P&P indicated To maintain the highest possible level of comfort for Residents by providing a system to identify, assess, treat, and evaluate pain. The P&P indicated, Residents would be evaluated as part of the nursing assessment process for the presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. The P&P indicated, The nurse would notify the physician as appropriate and obtain treatment orders as indicated.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to implement the facility ' s infection prevention and control program (IPCP) to prevent the development and transmission of communicable disease and infections for one of two sampled residents (Resident 4) who has diagnosis of Extended Spectrum Beta Lactamase (ESBL - an enzyme produced by bacteria that are resistant to a wide range of antibiotics making the bacteria more difficult to treat and transmitted through direct contact with infected individuals or by touching contaminated surfaces) resistance in the urine by failing to: 1. Communicate to facility staff that Resident 4 required the use of EBP Enhanced Barrier Precaution (EBP, infection control practices, designed to reduce the spread of multidrug-resistant organism [MDRO - multidrug-resistant organisms]) to wear appropriate personal protective equipment [PPE- specialized clothing or equipment worn to protect workers from work-place hazards)] during high contact resident care activities from 4/21/2025 to 4/23/2025. 2. Implement the physician ' s order from 4/21/2025 to 4/23/2025, to prevent the transmission of MDRO. During observations on 4/23/2025, Licensed Vocational Nurse (LVN) 1 failed to wear appropriate PPE (gown and gloves) during Resident 4 ' s medication administration and Certified Nurse Assistant (CNA) 8 failed to wear an isolation gown during Resident 4 ' s incontinence care. This deficient practice had the potential to result in an increased spread of infection in the facility among facility staff, residents, and visitors. Findings: During a review of Resident 4 ' s Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included ESBL resistance, unspecified Escherichia coli (E. coli, a type of bacteria that usually lives in the intestines of humans and animals), urinary tract infection (UTI, an infection in the bladder/urinary tract), and obstructive and reflux uropathy (blockage in the urinary tract that prevented urine from flowing, while reflux uropathy, also known as vesicoureteral reflux [VUR], was when urine flowed backward from the bladder into the ureters). During a review of Resident 4 ' s ESBL Care Plan initiated 11/7/2024, the Care Plan indicated a goal for the resident to have no signs or symptoms of infection in the next 90 days. The Care Plan indicated interventions of meticulous handwashing before and after each resident care, enhanced precautions, and proper use of PPE ' s during care. During a review of Resident 4 ' s History and Physical (H&P) dated 2/2/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/3/2025, the MDS indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 4 was always incontinent of bowel and bladder (losing control of your bladder or bowel, which could lead to accidental leakage of urine or stool) and was not in a bowel and bladder toileting program. The MDS indicated Resident 4 ' s active diagnoses included obstructive uropathy. The MDS indicated Resident 4 did not have any isolation precautions. During a review of Resident 4 ' s General Acute Care Hospital (GACH) Discharge Summary dated 4/20/2025, the Discharge Summary indicated Resident 4 had a UTI due to ESBL producing E. coli. The Discharge Summary indicated Resident 4 was to continue intravenous (IV, refers to a way of giving a drug through a needle or tube inserted into a vein) daptomycin (an antibiotic that was used to treat certain skin and bloodstream infections, particularly those caused by bacteria that were resistant to other antibiotics) and oral Levaquin (an antibiotic medication that treated bacterial infections) for a total of six weeks and oral nitrofurantoin (an antibiotic used to treat urinary tract infections) for seven more days. During a review of Resident 4 ' s Order Summary Report dated 4/21/2025, the Order Summary Report indicated a physician order to apply Enhanced Barrier Precautions. During an observation on 4/23/2025 at 11:07 AM, Resident 4 ' s room did not have an Enhanced Barrier Precaution communication or signage posted outside the door and did not have PPE cart placed in front of the resident ' s door or inside the resident ' s room. During an observation on 4/23/2025 at 3:08 PM in Resident 4 ' s room, LVN 1 was observed preparing and entered the room without wearing appropriate PPE (gloves and gown). LVN 1 administered the medication to Resident 4. During a concurrent interview and observation on 4/23/2025 at 3:12 PM, CNA 8 was observed changing Resident 4 ' s incontinent brief (absorbent undergarments designed to manage urine and/or bowel incontinence) and did not use proper PPE (isolation gown) during the incontinence care. CNA 8 stated she was not aware Resident 4 was supposed to be on isolation precautions. CNA 8 stated when residents were on isolation precautions there would be a signage posted in front of the resident ' s door indicating what precautions the resident would require and including an isolation cart with PPE in front of the door. CNA 8 stated there was no EBP signage posted on Resident 4 ' s door and no isolation cart with the appropriate PPE for staff to wear prior to rendering high contact activities with Resident 4. During a concurrent interview and record review on 4/23/2025 at 3:25 with CNA 8, Resident 4 ' s Order Summary Report was reviewed. CNA 8 stated Resident 4 ' s order for Enhanced Barrier Precautions meant when taking care of the resident, the facility staff needed to put on the appropriate PPE for EBP which included isolation gown and gloves. CNA 8 stated if the proper transmission-based precautions were not in place, the facility staff would not know that staff needs to wear PPE whenever performing direct care to Resident 4. CNA 8 stated that other residents, including Resident 4 could get sick. (continued on next page)

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	04/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/2025 at 3:32 PM with LVN 1, Resident 4 ' s Order Summary Report was reviewed. LVN 1 stated Resident 4 did not have a sign or PPE indicating the resident was on transmission-based precautions, as indicated in the facility ' s policy and procedure. LVN 1 stated the facility staff should have communicated to all facility staff, because there was an order for Enhanced Barrier Precautions for Resident 4 ' s ESBL of the urine. LVN 1 stated the facility staff must wear isolation gown and gloves when providing direct care and there should have been communication to ensure the proper precautions were in place. LVN 1 stated if the proper precautions were not in place that was an infection control issue and Resident 4 could be at more risk for infection including super bug infections (a microorganism [like bacteria, fungi, or viruses] that had become resistant to multiple types of antibiotics). LVN 1 stated having EBP was for the safety of everyone not only Resident 4 but for Resident 4 ' s roommate as well. During a concurrent interview and record review on 4/23/2025 at 3:51 PM with the Assistant Director of Nursing (ADON), Resident 4 ' s Order Summary Report was reviewed. The ADON stated Resident 4 did not have EBP in place. The ADON stated if EBP was not in place Resident 4 ' s condition could worsen, and the resident could have an infection because Resident 4 has an open wound and could possibly introduce a new bacteria or virus to the resident. During a review of the facilities Enhanced Standard Precautions (ESP) document revised 9/8/2023, the ESP indicated, Everyone must clean hands on room entry and when exiting and wear gloves and a gown for high-contact resident care activities. The ESP indicated, 6 moments for Enhanced Standard Precautions included 1. Activities of daily living (dressing, grooming, bathing, changing bed linens, feeding); 2. Toileting & changing incontinence briefs; 3. Caring for devices & giving medical treatments; 4. Wound care; 5. Mobility assistance & preparing to leave room; and 6. Cleaning the environment. During a review of the facility ' s policy and procedure (P&P) titled Infection Prevention and Control Program dated 9/18/2023, the P&P indicated An infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The P&P indicated Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures and implementing appropriate isolation precautions when necessary. (continued on next page)

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	056487	A. Building B. Wing	04/23/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Enhanced Standard/Barrier Precautions dated 3/27/2024 and revised 2/21/2025, the P&P indicated the policy of the facility was to Implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The P&P indicated compliance guidelines included Prompt recognition of need: The facility would have the discretion on how to communicate to staff which residents required the use of EBP, as long as stare were aware of which residents required the use of EBP prior to providing high-contact care activities. The P&P indicated The residents that would benefit from EBP were the following: infection or colonization with a Centers for Disease Control and Prevention (CDC, the US federal agency responsible for public health protection) targeted MDRO when Contact Precautions (wearing gloves and a gown to prevent the spread of germs from a patient or their environment through direct or indirect contact) do not otherwise apply. The P&P indicated to make PPE available near or outside of the resident ' s room. The P&P indicated high-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: PICC (peripherally inserted central catheters, a long, thing, flexible tube inserted into a vein in your arm and threaded to a large vein near your heart), and wound care: any skin opening requiring a dressing. The P&P indicated Additional epidemiologically important MDROs may include but were not limited to: ESBL - producing enterobacterales (a group of bacteria, many of which were commonly found in the gut).