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	06/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for two of two sampled residents (Resident 1 and 2), who required the use of a mechanical lift (device used to assist with transfers and movement of individuals who require support for mobility beyond manual support) for transfers. Resident 1 had experienced a fall from the mechanical lift on 5/16/2025 when Certified Nurse Assistants (CNAs) 2 and 3 did not provide Resident 1 with the correct sling (a flexible strap or belt used in the form of a loop to support or raise a weight), in accordance with Resident 1 ' s assessment. The facility failed to develop a comprehensive care plan for Resident 2 ' s use of the mechanical lift for transfers, in accordance with the resident assessment and the mechanical lift ' s manufacturer ' s manual titled, Battery Operated Patient Lift. Resident 2 had the potential to experience a fall on 6/10/2025 when CNA 1 did not follow the facility ' s policy and procedure titled Lifting Machine, Using a Mechanical, to assist Resident 2 with two persons while using the mechanical lift. The facility failed to develop a comprehensive care plan for Resident 2 ' s use of the mechanical lift for transfers, in accordance with the resident assessment and facility P&P. These deficient practices had the potential to result to falls with injuries to all residents requiring the use of mechanical lifts for transfers. Cross reference to F689 and F726. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/22/2008 and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted) affecting dominant side, muscle weakness, lack of coordination, contracture [a type of scarring in soft tissues (tissues that support, connect and surround other structures and organs in the human body) that causes them to tighten and stiffen] of right hand and right shoulder, osteoarthritis [the swelling and tenderness of one or more joints (places where two bones meet, such as the elbow or knee) that occurs when flexible tissue at the ends of bones wears down] of left hand, abnormalities of gait (manner of walking or moving on foot) and mobility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility document titled Lift Transfer Reposition, dated 1/7/2025, the assessment indicated Resident 1 was not able to transfer independently or with supervision without using a device. The assessment indicated, Resident 1 required a total lift with the use of a full body, extra-large size sling type for the mechanical life device. During a review of Resident 1 ' s Care plan, there was no documented evidence that a care plan for utilization of a mechanical lift for Resident 1 was developed and implemented. During a review of Resident 1 ' s Minimum Data Set (MDS-resident assessment tool), dated 5/12/2025, the MDS indicated Resident 1 ' s cognition (ability to think, remember, and reason) was intact, needed moderate assistance (helper does less than half the effort, helper lifts, holds or supports trunk or limbs, but provides less than half the effort) in transfer to and from bed to a chair and in toilet transfer (get on and off a toilet or commode) and needed maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) in tub/shower transfer (get in and out of tub/shower). During a review of Resident 1 ' s Change in Condition Evaluation, dated 5/16/2025, the evaluation indicated Resident 1 was transferred to the GACH emergency room (ER) due to injury at the back of the head, after slipping out of the sling during transfer from wheelchair to bed. During a review of Resident 1 ' s Progress Notes, dated 5/16/2025 timed at 11:48 PM documented by Licensed Vocational Nurse (LVN) 1, the Note indicated on 5/16/2025 at 4 PM, LVN 1 received Resident 1 during the night shift (11 PM-7 AM), after a fall from the mechanical lift sling with two CNAs present during the fall. The Note indicated Resident 1 was alert and oriented with vital signs within normal limits (no abnormalities) and no complaint of dizziness or pain. The Note indicated, there was a possible hematoma presented on the back of Resident 1 ' s head with the size of a tennis ball. During a review of Resident 1 ' s Progress Notes, dated 5/17/2025 documented at 1:22 AM, the Notes indicated, Resident 1 was readmitted back to the facility from the GACH with diagnosis of closed head injury without concussion. During a review of Resident 1 ' s Interdisciplinary (IDT) Care Conference (a meeting where healthcare professionals from different disciplines collaborate to discuss a patient's care plan) documentation by DON 2, dated 5/19/2025, the IDT note indicated an IDT discussion for Resident 1 ' s fall incident on 5/16/2025 at 4 PM. The IDT note indicated Resident 1 slipped out of the sling of the mechanical lift and fell on the floor while being transferred by two CNAs (CNAs 2 and 3). The IDT note indicated the sling was inspected by DON 2 with no signs of tear or breakdown. The IDT note further indicated Resident 1 was checked for any injury while on the floor. Resident 1 had a golf size area at the back of [the] head and was transferred to the bed with an aid of sheet and five nursing staff. Ice was applied to the back of the head. The IDT note indicated Resident 1 was transferred out via 911 and returned later that evening with no significant injuries identified. The IDT note further indicated It was noted that the sling used during transfer . may have been too small. This may have contributed to shift in her balance and consequence fall. The small sling was removed, and staff was instructed to use a larger size sling. During a review of Resident 1 ' s Care plan, there was no documented evidence that a care plan for utilization of a mechanical lift for Resident 1 was developed and implemented. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview of Resident 1, inside her room on 6/10/2025 at 11:55 AM, Resident 1 was observed sitting on the wheelchair. Resident 1 stated on 5/16/2025, two CNAs (CNAs 2 and 3) used the mechanical lift to transfer her from her wheelchair to the bed. Resident 1 then stated one CNA (could not recall which CNA) hooked the four corners of the slings to the mechanical lift. Resident 1 stated she felt the sling that was being used by the CNAs (CNAs 2 and 3) were too tight and asked the CNAs (CNAs 2 and 3) to wait, but CNAs 2 and 3 did not wait and started lifting her up in the air with the mechanical lift. Resident 1 stated while in the air, Resident 1 saw one of the sling connectors at the left upper corner come off the hook of the mechanical lift. Resident 1 then stated she slipped out of the sling and fell to the floor. Resident 1 stated she hit the back of her head onto the floor. Resident 1 stated that after the fall, she experienced pain at the back of the head and had nausea and vomiting. She stated after the fall, the nurses came to help her, and she was sent to the hospital. During a telephone interview on 6/11/2025 at 11:40 AM with CNA 2, CNA 2 stated she was asked to help Resident 1 ' s CNA (CNA 3) in transferring Resident 1 from the wheelchair to her bed on 5/16/2025 . CNA 2 stated one of the sling straps came loose causing Resident 2 to fall off the mechanical lift from her back side and hit her head on the floor . CNA 2 stated she was not aware that the resident ' s slings use for the mechanical lift come in different sizes. CNA 2 stated she had not been in serviced on how to use the mechanical lift or slings at the facility. During a telephone interview on 6/11/2025 at 12:06 PM with CNA 3, CNA 3 stated, the previous DON of the facility (DON 2), came into Resident 1 ' s room after Resident 1 ' s fall incident and explained to her (CNA 3) and CNA 2 that the blue sling used in Resident 1 ' s mechanical lift was too small because the hole where Resident 1 ' s buttocks went in was too small. CNA 3 stated she did not understand what DON 2 meant about the color of the sling. CNA 3 stated she was not trained by the facility on the colors/sizes of the slings to differentiate the correct sling size to use when moving the resident with the mechanical lift. CNA 3 stated, she was only trained on how to hook the mechanical lift sling into the mechanical lift when moving a resident. During a concurrent interview on 6/11/2025 at 3:46 PM and record review of Resident 1 ' s Lift Transfer Reposition, dated 1/7/2025, and the Comprehensive Care Plans developed from facility readmission dated 5/17/2025 to 6/11/2025, the MDS Nurse (MDSN) stated the facility had assessed Resident 1 for the use of a mechanical lift for transfers on 1/7/2025 and the CNAs had been using the mechanical lift to transfer Resident 1, but the licensed nurse did not develop a comprehensive care plan to address the use of mechanical lift for the safety of Resident 1 ' s transfers that addresses the appropriate slings to use. The MDSN stated it was important to develop and implement the care plan regarding the use of a mechanical lift to ensure staff to follow the interventions and instructions when using a mechanical lift and to ensure resident ' s safety during transferring. 2. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 6/13/2019 and readmitted on [DATE] with diagnoses that included contracture, quadriplegia (paralysis from the neck down, affecting all four limbs), contracture of upper arm muscle, contracture of right ankle, convulsion (seizure disorder - sudden surge of electrical activity in the brain when a person experiences abnormal behavior, symptoms, and sensations, sometimes including loss of consciousness), seizure, contracture of left knee and left ankle, and history of falling. During a review of Resident 2 ' s History and Physical (H&P), dated 4/19/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, requiring the assistance of 2 or more helpers for the resident to complete the activity) in bed to chair transfer, toilet transfer (get on and off a toilet or commode), and shower transfer (get in and out of shower). During a review of a facility record titled Lift Transfer Reposition, dated 4/28/2025, the record indicated Resident 2 was not able to transfer independently or with supervision without using a device. The assessment indicated, Resident 2 required a total lift device with the use of a full body, medium size sling type. During a review of Resident 2 ' s Care plan, there was no documented evidence that a care plan for utilization of a mechanical lift for Resident 2 was developed and implemented. During an observation on 6/10/2025 at 10:38 AM, in Resident 2 ' s room, Resident 2 was observed positioned in a sling and lifted in the air by a mechanical lift. During the observation, the Assistant Director of Nursing (ADON), entered Resident 2 ' s room while CNA 1 was operating the mechanical lift to transfer Resident 2 from the bed to a shower chair by herself. Resident 2 was positioned in a sling in mid-air. The ADON stated the facility ' s policy indicated the use of mechanical lift for transferring a resident required two people assistance. The ADON stated CNA 1 who was transferring the resident with the mechanical lift by herself put the resident at risk for fall and injury because the resident required two persons assist. During a subsequent interview on 6/10/2025 at 10: 45 AM with CNA 1, CNA 1 stated she was aware that two people were required to transfer a resident with the use of a mechanical lift. CNA 1 stated she saw other staff were busy, so she did not ask other staff for assistance before she transferred Resident 2 with the mechanical lift by herself. CNA 1 stated transferring Resident 2 with a mechanical lift by herself potentially have caused an accident to the resident and hurt Resident 2. During a concurrent interview and record review on 6/11/2025 at 3:50 PM with the MDS Nurse (MDSN), Resident 2 ' s Comprehensive Care Plan was reviewed. The MDSN stated Resident 2 required the use of mechanical lift for transferring, but they did not develop the care plan to address the use of a mechanical lift to transfer the resident. The MDSN stated it was important to develop and implement the care plan regarding the use of a mechanical lift to ensure staff to follow the interventions and instructions when using a mechanical lift and to ensure resident ' s safety during transferring. During a review of the facility ' s policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the following: -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; build on the resident ' s individualized needs; Identify the professional services that are responsible for each element of care; Aid in preventing or reducing declines in the resident ' s functional status and/or functional levels; Reflect currently recognized professional standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. During a review of the undated facility ' s P&P titled, Lifting Machine, Using a Mechanical, the P&P indicated at least two nursing assistants are needed to safely move a resident with a mechanical lift. During a review of the undated manufacturer ' s manual titled, Battery Operated Patient Lift, the manual indicated Always ensure the sling is the correct size and capacity for the patient being transferred.

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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 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Residents 1 and 2) reviewed for the use of a mechanical lift (a device used to assist with transfers and movement of individuals who require support for mobility beyond manual support), implemented interventions, provided adequate supervision and assistance to prevent falls and injury, while transferring from chair to bed to prevent accidents/ hazards by failing to: 1. Ensure Certified Nurse Assistants (CNAs) 2 and 3 provide Resident 1 with a full body, extra-large size sling (a flexible strap or belt used in the form of a loop to support or raise a weight) while using the mechanical lift, in accordance with the resident's Lift Transfer Assessment, during the resident's transfer from chair to bed on 5/16/2025. As a result, Resident 1 fell and landed on the floor when she slipped out from the small sling that was used by CNAs 2 and 3 to transfer the resident with the mechanical lift. 2. Implement interventions to reduce hazards and risks by not providing specific training and evaluation regarding the use of the correct size of a sling for resident transfers when using a mechanical lift. This deficient practice resulted to Resident 1 sustaining a golf-sized large bump, posterior swelling at the back of the head, pain at the back of the head, nausea/vomiting and transfer to the General Acute Care Hospital (GACH) via 911 emergency services (Emergency Medical Services, refers to the system that provides out-of-hospital medical care and transport to individuals in need, typically after a medical emergency or accident), on 5/16/2025. 3. Ensure at least two CNAs transfer Resident 2 using the mechanical lift on 6/10/2025, in accordance with the facility's policy and procedure (P&P) titled Lifting Machine, Using a Mechanical, when CNA 1 transferred Resident 2 by herself, with the mechanical lift from bed to the shower chair (a four-legged seat with rubberized feet made to provide support for bathtubs or showers). This deficient practice had the potential for Resident 2 to experience a fall and physical injuries while being transferred using the mechanical lift. Cross reference to F656 and F726. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/22/2008 and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted), muscle weakness, lack of coordination, contractures (a permanent tightening of the muscles, tendons [connects muscles to bones], skin, and nearby tissues that causes the joints to shorten and become very stiff) of right hand and right shoulder, osteoarthritis (the swelling and tenderness of one or more joints) of the left hand, abnormalities of gait (manner of walking or moving on foot) and mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of a facility record titled Lift Transfer Reposition, dated 1/7/2025, the record indicated Resident 1 was not able to transfer independently or with staff supervision without using a device. The assessment indicated, Resident 1 required a total lift (mechanical lift) with the use of a full body, extra-large size sling type for the mechanical life device. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 5/12/2025, the MDS indicated Resident 1's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort, helper lifts, holds or supports trunk or limbs, but provides less than half the effort) in transfer to and from bed to a chair and in toilet transfer (get on and off a toilet or commode) and needed maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) in tub/shower transfer (get in and out of tub/shower). During a review of Resident 1's physician order, dated 5/16/2025, the order indicated to transfer Resident 1 to the GACH via 911 EMS. During a review of Resident 1's record titled Change in Condition Evaluation, dated 5/16/2025, the record indicated Resident 1 was transferred to the GACH emergency room (ER) due to injury at the back of the head, after slipping out of the sling during transfer from wheelchair to bed. During a review of Resident 1's Progress Notes, dated 5/16/2025 timed at 4:48 PM documented by Registered Nurse (RN) 1, the Note indicated Resident 1 was sent to the GACH via 911 at 4:38 PM. During a review of Resident 1's Progress Notes, dated 5/16/2025 timed at 5:12 PM documented by Director of Nurses (DON) 2 (previous DON), the Note indicated Resident 1 was sent to the GACH via 911 due to possible hematoma (a closed wound where blood collects and fills a space inside your body because it cannot flow or drain out) at the back of the head. During a review of Resident 1's Progress Notes, dated 5/16/2025 timed at 11:48 PM documented by Licensed Vocational Nurse (LVN) 1, the Note indicated on 5/16/2025 at 4 PM, LVN 1 received Resident 1 during the night shift (11 PM to 7 AM), after a fall from the mechanical lift sling with two CNAs present during the fall. The Note indicated Resident 1 was alert and oriented with vital signs within normal limits (no abnormalities) and no complaint of dizziness or pain. The Note indicated, there was a possible hematoma presented on the back of Resident 1's head with the size of a tennis ball. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's GACH ED Physician Notes, dated 5/16/2025 electronically signed by the GACH Physician at 8:17 PM, the GACH ED Note indicated [Resident 1] was admitted to the GACH ED via EMS with a chief complaint of fall with head injury that was accidental as she was being transported by [facility] staff and hit her head. The GACH ED Note indicated, [Resident 1] hit her head on the back, reported no pain, but there is a large bump on the back of her head, with physical exam indicating a firm, 4 x 4-centimeter (cm - unit of measurement) round hematoma on the back of her head. The GACH ED Note indicated a Computerized Tomography (CT, a diagnostic imaging procedure that produces images of the inside of the body) of Resident 1's brain performed on 5/16/2025, indicated a posterior scalp (the back of the scalp, which is the area of skin covering the back of the head) soft tissue (the non-bone parts of the body that connect, support, or surround other structures and organs) swelling and no other acute abnormalities. The GACH ED Note indicated Resident 1's diagnosis as Closed head injury (a traumatic brain injury where the skull remains intact) without concussion (a mild blow to the head that affects brain function). The GACH ED Note indicated an ice pack was applied to Resident 1's head and was offered Tylenol (an over-the-counter pain medication) for pain but declined. The GACH ED Note indicated Resident 1 was discharged back to the facility, the same evening, on 5/16/2025. During a review of Resident 1's Progress Notes, dated 5/17/2025 documented at 1:22 AM, the Notes indicated, Resident 1 was readmitted back to the facility from GACH with diagnosis of closed head injury without concussion. During a review of Resident 1's Progress Note, dated 5/17/2025 timed at 1:34 AM, documented by LVN 1, the Note indicated Resident 1 had three episodes of nausea and vomiting, LVN 1 was informed by the GACH nurse (unidentified) that Resident 1 had a concussion and would have nausea and vomiting for three days. The Note indicated Resident 1's CT result was negative (no significant abnormalities seen) and Resident 1's physician was made aware. During a review of Resident 1's Interdisciplinary (IDT) Care Conference (a meeting where healthcare professionals from different disciplines collaborate to discuss a patient's care plan) documentation by DON 2, dated 5/19/2025, the IDT note indicated an IDT discussion for Resident 1's fall incident on 5/16/2025 at 4 PM. The IDT note indicated Resident 1 slipped out of the sling of the mechanical lift and fell on the floor while being transferred by two CNAs (CNAs 2 and 3). The IDT note indicated the sling was inspected by DON 2 with no signs of tear or breakdown. The IDT note further indicated Resident 1 was checked for any injury while on the floor. Resident 1 had a golf size area at the back of [the] head and was transferred to the bed with an aid of sheet and five nursing staff. Ice was applied to the back of the head. The IDT note indicated Resident 1 was transferred out via 911 and returned later that evening with no significant injuries identified. The IDT note further indicated It was noted that the sling used during transfer . may have been too small. This may have contributed to shift in her balance and consequence fall. The small sling was removed, and staff was instructed to use a larger size sling. During a review of Resident 1's Interdisciplinary Care Conference, dated 5/28/2025, the notes indicated a weekly IDT meeting was held to follow up on the fall incident that happened on 5/16/2025. The note indicated, the facility's Rehabilitation (care that can help a person get back, keep, or improve abilities that you need for daily life) Department reevaluated Resident 1's sling on 5/28/2025, to ensure that they were appropriate and the right size for Resident 1 and three slings were assigned and labeled specifically for Resident 1's use only. (continued on next page)

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	056487	A. Building B. Wing	06/11/2025

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview of Resident 1, inside her room on 6/10/2025 at 11:55 AM, Resident 1 was observed sitting on the wheelchair. Resident 1 stated on 5/16/2025, two CNAs (CNAs 2 and 3) used the mechanical lift to transfer her from her wheelchair to the bed. Resident 1 then stated one CNA (could not recall which CNA) hooked the four corners of the slings to the mechanical lift. Resident 1 stated she felt the sling that was being used by the CNAs (CNAs 2 and 3) were too tight and asked the CNAs (CNAs 2 and 3) to wait, but CNAs 2 and 3 did not wait and started lifting her up in the air with the mechanical lift. Resident 1 stated while in the air, Resident 1 saw one of the sling connectors at the left upper corner come off the hook of the mechanical lift. Resident 1 then stated she slipped out of the sling and fell to the floor. Resident 1 stated she hit the back of her head onto the floor. Resident 1 stated that after the fall, she experienced pain at the back of the head and had nausea and vomiting. She stated after the fall, the nurses came to help her, and she was sent to the hospital. During a telephone interview on 6/11/2025 at 11:40 AM with CNA 2, CNA 2 stated she was asked to help Resident 1's CNA (CNA 3) in transferring Resident 1 from the wheelchair to her bed on 5/16/2025. CNA 2 stated she did not touch Resident 1. CNA 2 stated she stood in front of Resident 1 and observed CNA 3 strap the mechanical lift sling into the mechanical lift. CNA 2 stated she asked CNA 3 if the sling straps were secured, and CNA 3 said yes. CNA 2 stated she then proceeded to operate the mechanical lift and lift Resident 1. CNA 2 stated one of the sling straps came loose causing Resident 2 to fall off the mechanical lift from her back side and hit her head on the floor. CNA 2 stated she went to call an LVN. CNA 2 stated she was not aware that the resident's slings use for the mechanical lift come in different sizes. CNA 2 stated she had not been in serviced on how to use the mechanical lift or slings at the facility. During a telephone interview on 6/11/2025 at 12:06 PM with CNA 3, CNA 3 stated that on 5/16/2025, Resident 1 asked to be changed so she asked CNA 2 to help her transfer Resident 1 from the wheelchair to the bed using the mechanical lift. CNA 3 stated, she hooked up three sling ties to the mechanical lift and CNA 2 hooked the fourth tie of the mechanical lift. CNA 3 stated she remembered telling CNA 2 that she was ready; as the mechanical lift went up, CNA 3 remembered Resident 1 moving to fix her buttocks and then fell to the floor. CNA 3 stated, the previous DON of the facility (DON 2), came into Resident 1's room after Resident 1's fall incident and explained to her (CNA 3) and CNA 2 that the blue sling used in Resident 1's mechanical lift was too small because the hole where Resident 1's buttocks went in was too small. CNA 3 stated she did not understand what DON 2 meant about the color of the sling. CNA 3 stated she was not trained by the facility on the colors/sizes of the slings to differentiate the correct sling size to use when moving the resident with the mechanical lift. CNA 3 stated, she was only trained on how to hook the mechanical lift sling into the mechanical lift when moving a resident. During a concurrent interview on 6/11/2025 at 3:46 PM and record review of Resident 1's Lift Transfer Reposition, dated 1/7/2025, and the Comprehensive Care Plans developed from facility readmission dated 5/17/2025 to 6/11/2025, the MDS Nurse (MDSN) stated the facility had assessed Resident 1 for the use of a mechanical lift for transfers on 1/7/2025 and the CNAs had been using the mechanical lift to transfer Resident 1, but the licensed nurse did not develop a comprehensive care plan to address the use of mechanical lift for the safety of Resident 1's transfers that addresses the appropriate slings to use. (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	06/11/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	2. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 6/13/2019 and readmitted on [DATE] with diagnoses that included contracture, quadriplegia (paralysis from the neck down, affecting all four limbs), contracture of upper arm muscle, contracture of right ankle, convulsion (seizure disorder - sudden surge of electrical activity in the brain when a person experiences abnormal behavior, symptoms, and sensations, sometimes including loss of consciousness), seizure, contracture of left knee and left ankle, and history of falling. During a review of Resident 2's History and Physical (H&P), dated 4/19/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decision. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, requiring the assistance of 2 or more helpers for the resident to complete the activity) in bed to chair transfer, toilet transfer (get on and off a toilet or commode), and shower transfer (get in and out of shower). During a review of a facility record titled Lift Transfer Reposition, dated 4/28/2025, the record indicated Resident 2 was not able to transfer independently or with supervision without using a device. The assessment indicated, Resident 2 required a total lift device with the use of a full body, medium size sling type. During an observation on 6/10/2025 at 10:38 AM, in Resident 2's room, Resident 2 was observed positioned in a sling and lifted in the air by a mechanical lift. During the observation, the Assistant Director of Nursing (ADON), entered Resident 2's room while CNA 1 was operating the mechanical lift to transfer Resident 2 from the bed to a shower chair by herself. Resident 2 was positioned in a sling in mid-air. The ADON stated the facility's policy indicated the use of mechanical lift for transferring a resident required two people assistance. The ADON stated CNA 1 who was transferring the resident with the mechanical lift by herself put the resident at risk for fall and injury because the resident required two persons assist. During a subsequent interview on 6/10/2025 at 10: 45 AM with CNA 1, CNA 1 stated she was aware that two people were required to transfer a resident with the use of a mechanical lift. CNA 1 stated she saw other staff were busy, so she did not ask other staff for assistance before she transferred Resident 2 with the mechanical lift by herself. CNA 1 stated transferring Resident 2 with a mechanical lift by herself potentially have caused an accident to the resident and hurt Resident 2. During a concurrent observation and interview on 6/11/2025 at 11:15 AM with Laundry Staff (LS) 1, multiple blue slings with numbers written on the corner of the slings were hung in the facility's Laundry Room. LS 1 stated that whenever CNAs would use the mechanical lift for residents, the CNAs would go and ask LS 1 for a sling. LS 1 stated the blue slings were used for transferring. LS 1 stated the blue slings had different color edges, light blue and purple. LS 1 stated the slings of the mechanical lift were the same size regardless of the color difference on the edge on the blue slings (light blue and purple). LS 1 stated she just gives the CNAs any blue slings when the CNAs asked her for a sling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 6/11/2025 at 11:17 AM with LS 1, LS 1 held one blue sling with the light blue edge and one blue sling with purple edge overlapping each other, and observed the blue sling with the light blue edge was larger than the sling with the purple edge. LS 1 stated she did not know the slings with different color edges were different sizes. LS 1 stated no one informed her or given her in-service of what sling sizes to provide the CNAs when they ask for a sling. During an interview on 6/11/2025 at 11:28 AM with the Maintenance Director (MD), the MD stated he was responsible for purchasing the slings for the mechanical lift in the facility, but he did not know there are different sizes and/or colors on the edge of the slings presented. During an interview on 6/11/2025 at 11:30 AM with the Housekeeping Supervisor (HKS), the HKS stated he did not know the connection between the different colors of the edge of the blue slings and the different sizing of the slings for each resident that uses the mechanical lift. The HKS stated he did not have any written document of the information and did not have any posting in the laundry area to guide the laundry staff such as LS1, when the laundry staff gives out the slings to the CNAs. During an interview on 6/11/2025 at 12:47 PM with CNA 1, CNA 1 stated she went to the facility's Laundry Room and asked the laundry staff for a sling for the resident she would use a mechanical lift to transfer the resident. CNA 1 stated the slings were the same and there was no difference in sizes. During an interview on 6/11/2025 3:30 PM with the Director of Staff Development (DSD), the DSD stated facility staff should choose the appropriate size of a sling when transferring a resident with a mechanical lift by identifying the correct color of the edge of the blue sling. The DSD stated if the wrong sling was used for the resident during transfers with the mechanical lift, it could lead to fall and injuries. The DSD stated she was new at the facility and had not trained the CNAs or conducted any skills competencies for the use of the mechanical lift and choosing the correct slings when transferring a resident according to the resident's weight and assessment. During a concurrent interview and record review of a facility record titled Portable Lift (mechanical lift) Competency Check List (undated), on 6/11/2025 at 4:35 PM with Director of Nursing (DON) 1, DON 1 stated the CNA competency check list for the portable lift does not include assessing for the mechanical lift sling size or reviewing resident assessments for recommended sling size based on the resident's weight. DON 1 stated using the correct size of a sling when transferring a resident with a mechanical lift could capture the resident's whole body and ensure the residents' safety during transferring to prevent falls and injury. DON 1 stated two staff were required to transfer a resident when using a mechanical lift to ensure resident's safety. During a review of the undated facility's policy and procedure (P&P) titled, Lifting Machine, Using a Mechanical, the P&P indicated at least two nursing assistants are needed to safely move a resident with a mechanical lift. The P&P indicated to measure the resident for proper sling size and purpose, according to manufacturer's instruction, double check the sling and machine's weight limits against the resident's weight, visually check the size to ensure it is not too large or too small, and attach sling straps to sling bar (a bar that attaches to the mechanical lift, providing connection point for slings, which support the resident during movement), according to manufacturer's instructions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's mechanical lift manufacturer's manual (a step-by-step document that guides workers through production processes, machine operation, and safety procedures) titled, Battery Operated Patient Lift, the manual indicated the mechanical lift should be used for transferring residents to and from/to a wheelchair, bed, commode, shower chair, floor, or similar. The P&P indicated to select a sling that will properly fit the resident and have the appropriate weight capacity and ensure that the sling and lift have compatible connection points. The P&P indicated under Sling Use Warnings to Use compatible slings and always ensure the sling is the correct size and capacity for the patient being transferred.

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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 0697 Level of Harm - 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** Based on observation, interview and record review, the facility failed to implement an effective pain management (the process of alleviating pain), in accordance with the physician's order, the resident's goals and comprehensive care plans for pain for one of three sampled residents (Resident 3) reviewed for pain, who has a diagnosis of chronic pain syndrome (persistent pain that lasts weeks to years) by: 1. Failing to ensure licensed nurses follow up with Resident 3's physician to sign a required medication order refill form (a document used to request a new supply of a medication that has previously been prescribed by the physician), after the resident missed the scheduled dose of fentanyl patch (a pain patch that applied on the skin and delivers pain relief through the bloodstream. It is used to treat severe, persistent pain in individuals who are already tolerant to opioid [very strong pain medications that treats severe pain] pain medications and who needs around-the-clock [lasting 24 hours a day], long-term pain relief) every 72 hours on 6/1/2025. 2. Failing to ensure licensed nurses assess Resident 3's pain level, evaluate pain characteristics and monitor for non-verbal signs/symptoms of pain, in accordance with the resident's care plan titled, Alterations in Comfort due to Uncontrolled Pain. Upon Resident 3's interview on 6/11/2025, Resident 3 verbalized he was in severe pain during the time the fentanyl patch was not administered (6/1/2025 to 6/7/2025), however, the SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers, dated 6/5/2025 indicated Resident 3 was not experiencing pain, despite the resident's verbalizing severe pain. As a result, Resident 3 experienced unrelieved pain when the resident missed two doses of fentanyl patch on 6/1/2025 and 6/4/2025. The fentanyl patch was later applied to Resident 3 for pain as ordered on 6/7/2025. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 3 on 7/18/2023 with diagnoses that included quadriplegia (severe medical condition characterized by the partial or total loss of function in all four limbs), chronic pain syndrome, depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), left hip osteoarthritis (the swelling and tenderness of one or more joints [places where two bones meet]), and opioid dependence (a state where the body adapts to the presence of opioids) During a review of Resident 3's History and Physical (H&P) dated 7/28/2023, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's care plan, revised on 2/28/2024, the care plan indicated Resident 3 exhibited or had the potential to demonstrate verbal behaviors related to depression and anxiety. The goal indicated for the resident to demonstrate effective coping skills related to verbal behavior. The care plan interventions included to monitor for pain and administer pain medication as ordered. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 3's care plan, revised on 10/23/2024, the care plan indicated Resident 3 exhibits or was at risk for alterations in comfort due to uncontrolled pain. The goal indicated for the resident to not experience pain and would achieve acceptable level of pain control. The care plan interventions included to apply one patch transdermally (delivered through the skin) every 72 hours for chronic pain management, evaluate pain characteristics, utilize pain scale, monitor for non-verbal signs/symptoms of pain and medicate as ordered. During a review of Resident 3's physician order, dated 10/30/2024, the order indicated Resident 3 to apply one patch of Fentanyl transdermal patch 25 micrograms/hour (mcg/hr - unit of measurement), every 72 hours, transdermally, at bedtime for chronic pain syndrome. During a review of Resident 3's Minimum Data Set (MDS-resident assessment tool), dated 4/4/2025, the MDS indicated Resident 3's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 3 was dependent (helper does all of the effort to complete the activity) in shower/bathe self, toilet hygiene and lower body dressing. During a review of Resident 1's physician orders dated 5/12/2025, the order indicated to administer 30 mg oxycodone HCL every 6 hours as needed for moderate to severe pain, 5-10 (pain scale - a tool used to help individuals describe and quantify their pain. It typically uses a numerical or visual scale, such as the 0-10 scale, where 0 represents no pain and 10 represents the worst pain imaginable). During a review of Resident 3's Medication Administration Record (MAR) for the month of May 2025, the MAR indicated, the facility applied fentanyl patch to Resident 3 on 5/29/2025. During a review of Resident 3's eMAR (electronic medical administration record) Progress Note (PN), dated 6/1/2025 timed at 3:30 PM, the eMAR PN indicated, Resident 3's fentanyl patch was Waiting for authorization for refill. During a review of Resident 3's Medication Administration Record (MAR) for the month of June 2025, the MAR indicated Resident 3's next fentanyl Patch schedule should be every 72 hours, on 6/1/2025, 6/4/2025, and 6/7/2025. The MAR indicated Resident 3 missed two doses of fentanyl patches, on 6/1/2025 and 6/4/2025. The MAR indicated the fentanyl patch was applied to Resident 3 on 6/7/2025 (6 days later than scheduled). During a review of a facility record titled SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers, dated 6/1/2025 timed at 11 PM, the SBAR indicated Resident 3 had a Change in Condition related to Resident 3 missing the fentanyl patch doses due to No medication available. The SBAR indicated the facility contacted the facility's pharmacy and a new order from Resident 3's physician was needed. The SBAR indicated, the facility notified Resident 3's physician and a new order was obtained and faxed to the pharmacy. The SBAR indicated, the new order for the fentanyl patch was On waiting for authorization and delivery. During a review of Resident 3's eMAR Progress Note (PN), dated 6/2/2025 timed at 11:17 PM, the eMAR PN, indicated the fentanyl patch was still Pending delivery. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 3's eMAR Progress Note (PN), dated 6/5/2025 timed at 8:05 PM, the eMAR PN indicated Resident 3's fentanyl patch was not available because Resident 3's physician had not signed the medication refill form. During a review of Resident 1's MAR with dates 6/1/2025 to 6/6/2025, the MAR indicated Resident 3 had received 30 mg oxycodone HCL every 6 hours as needed for moderate to severe pain, 5-10, on 6/1/2025, 6/2/2025, 6/3/2025, 6/4/2025, 6/5/2025, and 6/6/2025 with pain scale that ranges between 5 to 8. During a review of Resident 3's SBAR Summary for Providers, dated 6/5/2025 timed at 8:27 PM, the SBAR indicated, Resident 3 missed his Fentanyl patch because the physician did not sign the medication refill form, and that the physician would come the next day (6/6/2025) to sign the form. The SBAR indicated Resident 3's physician stated to offer Resident 3 oxycodone hydrochloride (HCL) (pain medication for moderate to severe pain that wears after 4 to 6 hours) 30 mg as needed for moderate to severe pain. However, the SBAR indicated, Resident 3 was not in pain or discomfort. During an interview and record review on 6/10/2025 at 2 PM with the Director of Nursing (DON) 1, DON 1 stated Resident 3's next fentanyl patch dose was to be administered on 6/1/2025, when the Licensed Vocational Nurse (LVN 7) needed to administer during the evening shift on 6/1/2025, and noticed the facility had run out of fentanyl patches for Resident 3. DON 1 stated LVN 7 called the Pharmacy to reorder refills for the fentanyl patch but the Pharmacy stated they would need to obtain a new order from Resident 3's physician. DON 1 stated LVN 7 called Resident 3's physician and obtained a telephone order which they faxed to the pharmacy that evening. DON 1 stated there was no documented evidence in Resident 3's records to indicate if facility staff had followed up with the pharmacy or Resident 3's physician to sign the medication order refill form needed for the pharmacy to refill and deliver Resident 3's fentanyl patches until the SBAR note dated 6/5/2025, 5 days after the initial missed dose on 6/1/2025. During an interview on 6/10/2025 at 2:13 PM with Pharmacist 1, Pharmacist 1 stated the facility should never run out of medication. Pharmacist 1 stated the facility staff should be reordering the resident's medication before the medication [NAME] out just in case there are any problems with the reordering, so it can be resolved before the medication is due, to ensure a resident never goes without missing any medication. During an interview on 6/11/2025 at 9:23 AM with Licensed Vocational Nurse (LVN 3), LVN 3 stated she was working during evening shift on 6/5/2025. LVN 3 stated that during medication pass she noticed Resident 3's fentanyl patch was not available. LVN 3 stated she was not aware it had not been available since 6/1/2025. LVN 3 stated she called the pharmacy to order the medication and was told they could not refill Resident 3's fentanyl patch medication until Resident 3's physician signed the medication order refill form. LVN 3 stated she then called Resident 3's physician who informed her he would be coming into the facility the following day (6/6/2025) and would sign the medication order refill form. LVN 3 stated she normally works the morning shift (7 am to 3 pm) and was not endorsed to follow up on Resident 3's missing medication. LVN 3 stated if the previous shift licensed nurses endorsed to her to follow up the reordering of the fentanyl patch, LVN 3 stated she would have followed up with Resident 3's physician and the pharmacy ahead of time. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/11/2025 at 11 AM with Resident 3, Resident 3 sounded upset. Resident 3 stated he was upset because he was missing his fentanyl patch medication and stated I keep bugging them (licensed nurses) for 9 days. Resident 3 stated he was in a lot of pain and would ask the nurses every day for the patch, but nurses would blame it to the other nurses from other shifts saying the other nurses had not ordered the medication. Resident 3 stated he was in a lot of pain, but facility staff would not believe him because They (facility staff) do not feel it (pain). Resident 3 further stated that he was in a lot of pain during the days that the facility staff failed to administer his fentanyl patch. During an interview on 6/11/2025 at 12:35 PM, Certified Nurse Assistant (CNA) 5, who had been caring for Resident 3 in the facility for the morning shifts, stated Resident 3 was always in pain. During an interview on 6/11/2025 at 4:35 PM with DON 1, DON 1 stated Nurses should check residents' medication and reorder medications before it ran out. DON 1 stated the licensed nurses should have followed up Resident 3's fentanyl patch medication order form, the next day on 6/2/2025, with the Pharmacy and Resident 3's physician and should have endorsed to the next shift to follow up. DON 1 stated if Resident 3 misses his scheduled fentanyl patch, it can lead to withdrawal from the medication, and unrelieved pain. During a review of the facility's policy and procedure (P&P) titled, Pain Management, dated 8/25/2021, the P&P indicated the purpose of pain management was to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. The facility is responsible for pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences is provided to residents who require such service. During a review of the facility's P&P titled, Medication Orders and Receipt Record, revised on April 2007, the P&P indicated Medications should be ordered in advance, based on the dispensing pharmacy's required lead time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure five of five sampled certified nurse assistants (CNAs 1, 2, 3, 4 and 7) reviewed for skills competencies, were trained and competent in using the mechanical lift device (a piece of equipment designed to safely and easily take the whole weight of an individual with limited mobility from one place to another), in accordance with the facility ' s Policy and Procedure (P&P) titled, Lifting Machine, Using a Mechanical. As a result, Certified Nurse Assistants (CNAs) 2 and 3 did not provide Resident 1 with the correct sling (a flexible strap or belt used in the form of a loop to support or raise a weight), in accordance with Resident 1 ' s assessment. CNAs 2 and 3 used a small sling, instead of a full body, extra-large size sling, while using the mechanical lift during the resident ' s transfer from chair to bed on 5/16/2025. Resident 1 slipped out from the small sling that was used by CNAs 2 and 3 to transfer the resident with the mechanical lift on 5/16/2025. This deficient practice resulted to Resident 1 sustaining a golf-sized large bump, posterior swelling at the back of the head, pain at the back of the head, nausea/vomiting and transfer to the General Acute Care Hospital (GACH) via 911 emergency services (Emergency Medical Services, refers to the system that provides out-of-hospital medical care and transport to individuals in need, typically after a medical emergency or accident), on 5/16/2025. This deficient practice can further result to other resident injuries while using the incorrect sling size with the mechanical lift. Cross reference to F689 and F656. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/22/2008 and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted) affecting dominant side, muscle weakness, lack of coordination, contracture [a type of scarring in soft tissues (tissues that support, connect and surround other structures and organs in the human body) that causes them to tighten and stiffen] of right hand and right shoulder, osteoarthritis [the swelling and tenderness of one or more joints (places where two bones meet, such as the elbow or knee) that occurs when flexible tissue at the ends of bones wears down] of left hand, abnormalities of gait (manner of walking or moving on foot) and mobility. During a review of a facility record titled Lift Transfer Reposition, dated 1/7/2025, the record indicated Resident 1 was not able to transfer independently or with supervision without using a device. The assessment indicated, Resident 1 required a total lift with the use of a full body, extra-large size sling type for the mechanical life device. During a review of Resident 1 ' s Progress Notes, dated 5/16/2025 timed at 4:48 PM documented by Registered Nurse (RN) 1, the Note indicated Resident 1 was sent to the GACH via 911 at 4:38 PM. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Progress Notes, dated 5/16/2025 timed at 5:12 PM documented by the Director of Nurses (DON) 2 (previous DON), the Note indicated Resident 1 was sent to the GACH via 911 due to possible hematoma (a closed wound where blood collects and fills a space inside your body because it cannot flow or drain out) at the back of the head. During a review of Resident 1 ' s GACH ED Physician Notes, dated 5/16/2025 electronically signed by the GACH Physician at 8:17 PM, the GACH ED Note indicated [Resident 1] was admitted to the GACH ED via EMS with a chief complaint of fall with head injury that was accidental as she was being transported by [facility] staff and hit her head. The GACH ED Note indicated, [Resident 1] hit her head on the back, reported no pain, but there is a large bump on the back of her head, with physical exam indicating a firm, 4 x 4-centimeter (cm - unit of measurement) round hematoma on the back of her head. The GACH ED Note indicated a Computerized Tomography (CT, a diagnostic imaging procedure that produces images of the inside of the body) of Resident 1 ' s brain performed on 5/16/2025, indicated a posterior scalp (the back of the scalp, which is the area of skin covering the back of the head) soft tissue (the non-bone parts of the body that connect, support, or surround other structures and organs) swelling and no other acute abnormalities. The GACH ED Note indicated Resident 1 ' s diagnosis as Closed head injury (a traumatic brain injury where the skull remains intact) without concussion (a mild blow to the head that affects brain function). The GACH ED Note indicated an ice pack was applied to Resident 1 ' s head and was offered Tylenol for pain but declined. The GACH ED Note indicated Resident 1 was discharged back to the facility, the same evening, on 5/16/2025. During a review of Resident 1 ' s Progress Notes, dated 5/16/2025 timed at 11:48 PM documented by Licensed Vocational Nurse (LVN) 1, the Note indicated on 5/16/2025 at 4 PM, LVN 1 received Resident 1 during the night shift (11 PM-7 AM), after a fall from the mechanical lift sling with two CNAs present during the fall. During a review of Resident 1 ' s Interdisciplinary (IDT) Care Conference (a meeting where healthcare professionals from different disciplines collaborate to discuss a patient's care plan) documentation by DON 2, dated 5/19/2025, the IDT note indicated an IDT discussion for Resident 1 ' s fall incident on 5/16/2025 at 4 PM. The IDT note indicated Resident 1 slipped out of the sling of the mechanical lift and fell on the floor while being transferred by two CNAs (CNAs 2 and 3). The IDT note further indicated It was noted that the sling used during transfer . may have been too small. This may have contributed to shift in her balance and consequence fall. The small sling was removed, and staff was instructed to use a larger size sling. Further review of the same IDT notes indicated, the risk factor with the use of mechanical lift and IDT recommendations for Resident 1 ' s post-fall included: neurochecks, use of larger size sling, resident ' s education about the size of sling, and staff ' s education in use of appropriate size sling per resident ' s size and weight. During a review of Resident 1 ' s Interdisciplinary Care Conference, dated 5/28/2025, the note indicated, the facility ' s Rehabilitation (care that can help a person get back, keep, or improve abilities that you need for daily life) Department reevaluated Resident 1 ' s sling on 5/28/2025, to ensure that they were appropriate and the right size for Resident 1 and three slings were assigned and labeled specifically for Resident 1 to be used alternatively. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2025 at 2:11 PM with Certified Nurse Assistant (CNA) 4, CNA 4 stated she had been working for the facility for three years and had not been provided with an in-service for the use of the mechanical lift and the correct sling size according to resident ' s weight or assessment, from the Director of Staff Development (DSD) or the DON. CNA 4 stated, she learned from another coworker CNA how to use the mechanical lift and was told to use the blue sling for all types of residents as they were all the same size. During a telephone interview on 6/11/2025 at 11:40 AM with CNA 2, CNA 2 stated she was asked to help Resident 1 ' s CNA (CNA 3) in transferring Resident 1 from the wheelchair to her bed on 5/16/2025 . CNA 2 stated one of the sling straps came loose causing Resident 2 to fall off the mechanical lift from her back side and hit her head on the floor. CNA 2 stated she went to call an LVN. CNA 2 stated she was not aware that the resident ' s slings use for the mechanical lift come in different sizes. CNA 2 stated she had not been in serviced on how to use the mechanical lift or slings at the facility. CNA 2 stated she had not been informed by the DSD that there were supposed to be different sling sizes to be used for the mechanical lift. During a telephone interview on 6/11/2025 at 12:06 PM with CNA 3, CNA 3 stated Resident 1 asked to be changed so she asked CNA 2 to help her transfer Resident 1 from the wheelchair to the bed using the mechanical lift . CNA 3 stated, the previous DON of the facility (DON 2), came into Resident 1 ' s room after Resident 1 ' s fall incident and explained to her (CNA 3) and CNA 2 that the blue sling used in Resident 1 ' s mechanical lift was too small because the hole where Resident 1 ' s buttocks went in was too small. CNA 3 stated she did not understand what DON 2 meant about the color of the sling. CNA 3 stated she was not trained by the facility on the colors/sizes of the slings to differentiate the correct sling size to use when moving the resident with the mechanical lift. CNA 3 stated, she was only trained on how to hook the mechanical lift sling into the mechanical lift when moving a resident. During a concurrent observation and interview on 6/11/2025 at 11:15 AM with Laundry Staff (LS) 1, multiple blue slings with numbers written on the corner of the slings were hung in the facility ' s Laundry Room. LS 1 stated that whenever CNAs would use the mechanical lift for residents, the CNAs would go and ask LS 1 for a sling. LS 1 stated the blue slings were used for transferring. LS 1 stated the blue slings had different color edges, light blue and purple. LS 1 stated the slings of the mechanical lift were the same size regardless of the color difference on the edge on the blue slings (light blue and purple). LS 1 stated she just gives the CNAs any blue slings when the CNAs asked her for a sling. During a concurrent observation and interview on 6/11/2025 at 11:17 AM with LS 1, LS 1 held one blue sling with the light blue edge and one blue sling with purple edge overlapping each other, and observed the blue sling with the light blue edge was larger than the sling with the purple edge. LS 1 stated she did not know the slings with different color edges were different sizes. LS 1 stated no one informed her or given her in-service of what sling sizes to provide the CNAs when they ask for a sling. During an interview on 6/11/2025 at 11:28 AM with the Maintenance Director (MD), the MD stated he was responsible for purchasing the slings for the mechanical lift in the facility, but he did not know there are different sizes and/or colors on the edge of the slings presented. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/2025 at 12:47 PM with CNA 1, CNA 1 stated whenever she needs a sling to use for the mechanical lift she would go to the laundry room and asked the laundry staff for a sling to be used for a resident for the mechanical lift. CNA 1 stated the slings available in the facility laundry room were all the same color and there was no difference in sling sizes. CNA 1 stated she did not know there were different sling sizes. During an interview on 6/11/2025 at 1:35 PM with CNA 7, CNA 7 stated, she was trained to use the mechanical lift by another coworker CNA but was not made aware about the different sizes of slings to use according to the resident ' s weight or assessment. During an interview on 6/11/2025 3:30 PM with the Director of Staff Development (DSD), the DSD stated facility staff should choose the appropriate size of a sling when transferring a resident with a mechanical lift by identifying the correct color of the edge of the blue sling. The DSD stated if the wrong sling was used for the resident during transfers with the mechanical lift, it could lead to fall and injuries. The DSD stated she was new at the facility and had not trained the CNAs or conducted any skills competencies for the use of the mechanical lift and choosing the correct slings when transferring a resident according to the resident's weight and assessment. During a concurrent interview and record review of a facility record titled Portable Lift (mechanical lift) Competency Check List (undated), on 6/11/2025 at 4:35 PM with Director of Nursing (DON) 1, DON 1 stated the CNA competency check list for the portable lift does not include assessing for Hoyer lift sling size or reviewing resident assessments for recommended sling size based on resident weight. During a review of the facility ' s P&P titled, Competency of Nursing Staff, undated, the P&P indicated licensed nurses and nursing assistants employed (or contracted) by the facility will participate in a facility-specific, competency-based staff development and training program; and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. Facility and resident-specific competency evaluations will include demonstrated ability to use tools, devices, or equipment used to care for residents. During a review of the facility ' s Policy and Procedure (P&P) titled, Lifting Machine, Using a Mechanical, undated, the P&P indicated staff must be trained and demonstrated competency using the specific machines or devices utilized in the facility. During a review of the facility ' s mechanical lift manufacturer ' s manual (a step-by-step document that guides workers through production processes, machine operation, and safety procedures) titled, Battery Operated Patient Lift, the manual indicated the mechanical lift should be used for transferring residents to and from/to a wheelchair, bed, commode, shower chair, floor, or similar. The P&P indicated to select a sling that will properly fit the resident and have the appropriate weight capacity and ensure that the sling and lift have compatible connection points. The P&P indicated under Sling Use Warnings to Use compatible slings and always ensure the sling is the correct size and capacity for the patient being transferred. During a review of the facility records titled Initial and Competency Checklist for the month of April 2025, the checklist indicated the following information for CNAs 1, 2, 3, and 4: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Education and skills competency was conducted by the DSD consultant on CNA 1 dated 4/10/2025, CNA 2 on 4/16/2025, CNA 3 on 4/10/2025, and CNA 4 on 4/9/2025. 2. The Competency Checklists for CNAs 1, 2, 3, and 4 included a topic titled Portable Lift, and covered the following subtopics: -Identifies components of the portable lift -Sling use and operation that included examining the sling for durability, loop positions, demonstrating proper sling placement, demonstrate putting the sling under the resident, demonstrate sling leg support positions, and demonstrate use of limb lift. -Portable lift operation that included locking the wheels, position of lift over the resident, proper sling/loop attachment, demonstrate operation/transfer of the resident (moving and lowering the resident from the lift), and demonstrate sling removal. The Competency Checklist did not include a demonstration how the facility staff would ensure the sling is the correct size and capacity for the resident being transferred, in accordance to the mechanical lift manufacturer ' s manual titled, Battery Operated Patient Lift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Potassium Chloride (KCL-a mineral supplement to replenish the loss of potassium in the body to maintain normal body function) was administered for one of two sampled residents reviewed for medication administration (Resident 5) as ordered by the physician and in accordance with the facility ' s policy and procedure titled, Administering Medications. The facility documented KCL was administered on 6/5/25 to 6/9/25 but there were three KCL packets remaining in Resident 5 ' s supply that were not administered. These deficient practices had potential for Resident 5 to be at risk for medication error or hypokalemia (low KCL level in the blood) that can lead to cramping, irregular heartbeat and cardiac arrest (heart ceases in functioning). Findings: During a review of Resident 5 ' s admission Record indicated the facility originally admitted Resident 5 on 11/23/19 and readmitted on [DATE] with diagnoses that included seizure (a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings, and levels of consciousness) and paraplegia (the inability to voluntarily move the lower parts of the body). During a review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/10/2025, indicated Resident 5 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 5 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene and personal hygiene, and was dependent with toileting hygiene and chair/bed-to-chair transfer. During a review of Resident 5 ' s Lab Results Report, dated 6/4/2025, the report indicated Resident 5 ' s Potassium level was at 3.2 Milliequivalent (MEQ, a unit of measurement/Millimeter (ML, a unit of measurement) which was low (reference range 3.5-5). During a review of Resident 5 ' s Order Summary Report, dated 6/10/2025, indicated the physician ordered to administer KCL oral (by mouth) packet 20 MEQ one packet daily (without end date ordered). During a review of Resident 5 ' s Medication Administration Record (MAR), dated 6/2025, indicated for Resident 5 to receive KCL Oral (given by mouth) Packet 20 MEQ one packet on 6/5/2025 to 6/10/2025. During a concurrent observation and interview on 6/10/2025 at 6:05 AM with Registered Nurse (RN) 1, RN 1 looked through Medication Cart 1 and found KCL in one of the drawers that was labeled with Resident 5 ' s name with an open date of 6/5/25 that was not administered to Resident 5. RN 1 stated there were 28 individual packets of KCL inside the manufacturer box that should had been administered to Resident 5. RN 1 stated the pharmacy label on the box indicated 30 packets were in the box. RN 1 stated these were the only KCL packets that belongs to Resident 5 in Medication Cart 1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/10/2025 at 9:40 AM with Family Member (FM)1, FM 1 stated the physician prescribed KCL for Resident 5 starting on 6/4/2025 because Resident 5 ' s Potassium level was low. FM 1 stated she went to visit Resident 5 on 6/9/2025 and observed the charge nurse did not administer KCL to Resident 5. FM 1 stated she asked the charge nurse why Resident 5 did not receive KCL, the charge nurse replied to FAM 1 that KCL was not available. FM 1 stated she repeatedly inquired about the resident ' s (Resident 5) KCL, until the charge nurse finally administered KCL to Resident 5 around 3 PM on 6/9/25. During an interview on 6/10/2025 at 9:45 AM with Resident 5, Resident 5 stated he did not receive his KCL until 3 PM on 6/9/2025 because the charge nurse could not find the Potassium Chloride (KCL) in the medication cart. During a concurrent observation and interview on 6/10/2025 at 1:30 PM with LVN 1, LVN 1 counted Resident 5 ' s KCL packet from the manufacturer ' s box. LVN 1 stated she administered one packet of KCL this morning (6/10/2025) and there were 27 packets left in the box now after removing one packet. LVN 1 stated Resident 5 ' s KCL packet was the only place the packet was stored. During a telephone interview on 6/10/2025 at 1:35 PM with LVN 3, LVN 3 stated if Resident 5 ' s MAR indicated KCL was administered by her, then she must have administered the KCL. LVN 3 did not explain why there was remaining KCL packets in the medication cart for Resident 5. During a concurrent interview and record review on 6/10/2025 on 2:19 PM with Pharmacist 1, Resident 5 ' s MAR, dated 6/2025, and the Pharmacy Delivery Track (a receipt of medications delivered to the facility), dated 6/5/2025 were reviewed. Pharmacist 1 stated three packets of KCL for Resident 5 were not accounted for based on the number of KCL packet left in the box and the Pharmacy Delivery Track. Pharmacist 1 stated this discrepancy could be due to the nurses not administering the medication as ordered by the physician, but the nurses documented KCL was administered in the MAR even when there was remaining KCL packets. Pharmacist 1 stated the discrepancy could lead to medication error and potential harm to the resident. Pharmacist 1 stated the nurses should have documented accurately to reflect the actual administration of medication. During a concurrent interview and record review on 6/10/2025 at 2:43 PM with the Director of Nursing (DON), Resident 5 ' s MAR, dated 6/2025, the Pharmacy Delivery Track, dated 6/5/2025, Resident 5 ' s Progress Note, dated from 6/5/2025 to 6/10/2025, were reviewed. The DON stated the pharmacy delivered 30 packets of KCL on 6/5/2025 and Resident 5 ' s MAR indicated the nurses administered KCL oral packet 20 MEQ one packet daily to Resident 5 for five days from 6/5/2025 to 6/9/2025. There should be 25 packets of KCL left in the box as 6/10/2025 at 6:05 AM, but there were 28 packets left in the box this morning. The DON stated three extra KCL packets that were not accounted for and there was a discrepancy in the nurses ' documentation of administrations of KCL that did not match the number KCL left in the box. The DON stated the nurse should document accurately the administration of medication to prevent medication error, overdose and underdose of the medication. During a review of facility ' s policy and procedures (P&P) titled, Administering Medications, dated 4/2019, indicated Medications are administered in a safe and timely manner, and as prescribed, If a drug is withheld, refused, or given at a time other than the scheduled, document refusal, and Medications ordered for a particular resident may not be administered to another resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to safely store and discard drugs and biologicals in accordance with the professional standard of practice for one of eight sampled residents reviewed for medication storage (Resident 4) who expired on [DATE]. Resident 4 who was no longer at the facility but medications were still stored in the Medication Room in a locked box with code that the facility could not unlock and the facility had no record of the drug contents in the box. This deficient practice had potential to lead to drug diversion and/or misuse of Resident 4's medications. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on [DATE] and readmitted on [DATE] with diagnoses that included sepsis [a body's overwhelming and life-threatening response to infection (the invasion and growth of germs in the body)], type 2 diabetes mellitus (DM2 - condition that results in too much sugar circulating in the blood), end stage renal disease (ESRD - a stage where the kidneys can no longer support the body's needs for waste removal and fluid balance), and anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells, resulting in pallor and weariness). During a review of Resident 4's physician order, dated [DATE], indicated Resident 4's body was released due to resident's expiration on [DATE]. During a concurrent observation and interview on [DATE] at 6:25 AM with Registered Nurse (RN) 1 in Nursing Station 1's Medication Room, a locked black box with security code panel labeled with Resident 4's name was found on the top shelf of the storage cabinet. RN 1 stated she did not know there was a box of medication on the top shelf of the cabinet, and she did not know the code to open the box. RN 1 stated she did not know what medications were inside the box and if the resident's name labeled on the box had expired or had been discharged . During a concurrent interview and record review on [DATE] at 2:07 PM with Director of Nursing (DON) 1, DON 1 stated the facility policy does not have specific instruction regarding what to do with the medications for the residents who expired in the facility. DON 1 stated Resident 4's medication should had been discarded a long time ago to prevent diversion or misuse of the medications. DON 1 stated she could not open the medication box and did not know what medications were inside the box and or if there was any controlled medications inside the box. DON 1 stated Resident 4 expired on [DATE] and the facility staff should have discarded the medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the undated facility's policy and procedure titled Medication Labeling and Storage indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.