

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER Rio Hondo Subacute & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered as prescribed and appropriately monitored for one of six sampled resident's (Resident 2) reviewed for medication administration. During an observation conducted on 6/30/2025 at 11AM, a plastic medication cup containing unadministered medications was found on the resident's bedside table. Review of the Medication Administration Record (MAR) indicated that the medication had been documented as administered at 9:23AM, although it remained untouched over 90min later. This deficient practice had the risk of medication errors, missed doses, and adverse health outcomes. Findings: During a review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with a primary diagnosis of anemia (a condition when the red blood cells carrying oxygen is not sufficient) and displacement of nephrostomy catheter (a tube from kidney has been moved out of its correct place and is no longer connected to the drainage bag). During a review of Resident 2's History and Physical (H&P) dated 2/28/2025, indicated Resident 2 was alert and oriented x3 (a person knows who they are, where they are, and what time it is). During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/11/2025, indicated Resident 2 was cognitively intact (having normal or unimpaired ability to think, reason, remember, and make decisions). During a review of Resident 2's Care Plan titled Missing Medication 5/22/25 - Juven date revised on 5/22/2025, indicated a goal to have no changes in LOC with interventions to monitor Resident 2. During a review of Resident 2's Care plan, dated 1/2/2025, titled Resident missed his medication - Oxycodone (medication administered to relieve pain) yesterday with a goal that Resident will have no negative outcome and interventions to include Medical Doctor made aware. During a review of Resident 2's Care plan titled Resident received the wrong pain medications from 2/27/2025 - 2/28/2025, with a goal that Resident will have no complication following wrong medication given and intervention of Medical Doctor made aware. During a review of Resident 2's Care plan titled Risk for Adverse effect or complication related to missed dose of medication - Gabapentin - a class of medication call anticonvulsants that treats seizures dated 4/10/2025, with a goal that Resident will have no adverse effects or complications and intervention to monitor vital signs and symptoms for adverse effects or complications. During an observation on 6/15/2025 at 11AM, in Resident 2's room, Resident 2 was sleeping with 6 pills in a medication cup at the bedside table without a nurse in the room. In a concurrent interview Resident 2 stated she has not taken her medication at the bedside because Oh I was sleeping. During a concurrent observation and interview on 6/15/2025 at 11:02 AM with Licensed Vocation Nurse (LVN)1, Resident 2's was observed with 6 pills in a medication cup at the bedside table that was left unattended. LVN1 stated, I had just placed the medications on the bedside table but was called out of the room. LVN 1 stated the resident usually takes his medication as instructed. During a concurrent interview and record review on 6/15/2025 at 11:02AM with Licensed Vocational Nurse (LVN)1, Resident 2's Medication Administration Record (MAR), dated 6/30/2025 was reviewed. The MAR indicated, on 6/30/2025 at 9:23AM the following medications were documented as given by LVN1. Vitamin C 500Mg chewable- (vitamin supplement) Aspirin chewable 81 mg- (used to relieve mild pain and reduce fever and inflammation) Iron 325 mg (supplement) Gabapentin 300mg- (a class of medication call anticonvulsants that treats seizures) Multivitamin with minerals - (Vitamin and mineral supplement) Zinc 220mg - (a mineral that is good for immune system) During a concurrent interview on 6/15/2025 at 11:02AM, LVN 1 stated, it is important to ensure the medications were taken by Resident 2 in her presence to confirm the resident has taken the prescribed medication, to prevent a missed dose, and to ensure medication was not taken by wrong resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, (no date), the P&P indicated, that medications are to be administered in a safe and timely manner as prescribed. The P&P indicated The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The P&P further indicated For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations, Interviews and record review the facility failed to ensure that trash, debris and clutter did not accumulate for one of six sampled residents' (Resident 5) rooms observed for clean and sanitary environment, in accordance with the facility's policy and procedures (P&P) titled Homelike Environment. This failure had the potential to increase the risk of infection, attract pests such as ants, and cockroaches, and increased Resident 5's fall risk which could compromise the resident's health, safety, and overall quality of life. Findings: During an observation on 6/30/2025 at 11:35 AM, in Resident 5's room, Resident 5's environment was observed to be cluttered and unsanitary. During the observation, trash and debris were piled up across the floor consisting of a used cover (lid used to cover meal plate) from a breakfast tray on top of a pile of empty boxes, used plastic bottles, and empty drink cartons. There were also used eating utensils observed on Resident 5's bedside table. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 3/4/2025, with a diagnosis of urinary tract infection (bacteria in the bladder, kidneys, and the tubes that carry urine) and chronic obstructive pulmonary disease(long- term lung condition that makes it hard to breath). During a review of Resident 5's History and Physical examination (H&P), dated 4/2025, the H&P indicated, Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/10/2025, the MDS indicated the resident showed no signs of memory loss, confusion, or disorientation and is fully alert. During a review of Resident 5's Care Plan titled Resident is at risk for fall/ injury dated 3/31/2025, the MDS indicated a goal to have no injury related to falls and intervention to maintain a clutter - free environment in the resident's room and consistent furniture arrangement. During a concurrent observation in Resident 5's room and interview on 6/30/2025 at 11:35 AM, Resident 5 stated the trash, and clutter had been in his room for approximately two weeks. Resident 5 stated his room always looks cluttered. During a concurrent observation and interview on 6/30/2025 at 1:38 PM, with the Assistant Director of Nursing (ADON), in Resident 5's room, the ADON stated The empty boxes should not be kept in the resident's room. The ADON stated cleaning of the resident's rooms should be done two times a day by Housekeeping. The ADON stated the CNAs, and licensed nurses were responsible for contacting housekeeping to ensure the resident's room were kept clean and free of clutter. The ADON stated the clutter and debris in the resident's room creates a hazard to the resident's environment and predisposes Resident 5 to falls. The ADON stated Resident 5 frequently orders various items online, including drinks, snacks, and bottled water and stores the delivered items inside his room. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, indicated, Resident are provided with a safe, clean, comfortable and homelike environment.' The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include having a clean, sanitary and orderly environment.</p>		