

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  08/09/2025
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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record reviews, the facility failed to ensure one of five sampled residents (Resident 1) reviewed for falls, who was identified at risk for falls, and assessed as dependent for bed mobility with the use of a mechanical lift (a sling placed under or around the resident to lift or transfer a resident using a mechanical equipment), received adequate assistance to prevent accidents while laying on a low air loss mattress (LAL; a special type of mattress) for alternation therapy (also called alternating pressure therapy on a LAL mattress that involves a system that inflate [increase in size when filled with air] and deflate [decrease in size when filled with air] in cycles, redistributing pressure across the patient's body), by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Certified Nurse Assistant (CNA) 1 implement Resident 1's care plan to utilize the mechanical lift during bed mobility when CNA 1 repositioned Resident 1 in bed on 7/21/2025, during the nightshift (11 PM to 7 AM).</li> <li>2. Ensure CNA 1 asked for staff assistance to ensure at least two people assisted Resident 1 during turning/repositioning and activities of daily living (ADL - self care tasks of everyday life) care in bed on 7/21/2025, as indicated in Resident 1's transfer assessment titled Resident 1's Lift Transfer Reposition.</li> <li>3. Ensure CNA 1 delay repositioning until the LAL mattress was firm and stable to reposition Resident 1 in bed on 7/21/2025, when CNA 1 noticed that the alternation therapy of the resident's LAL continued to inflate and deflate, after Licensed Vocational Nurse (LVN) 4 reset the LAL mattress on static mode (In static mode, the LAL are fully inflated, creating a firm, stable surface. This is beneficial in situations where a stable surface is needed such as for turning and repositioning in bed), in accordance with the physician's order to place the resident on an LAL mattress and monitor the settings. As a result of these deficient practices, Resident 1 slid off from left side of the LAL mattress during turning and repositioning, causing the resident to fall to the floor on the left side of the bed. Resident 1 verbalized being in significant pain with 10/10 (pain level numbers, typically on a scale of 0 to 10, represent the subjective intensity of pain a person is experiencing, with 0 being no pain and 10 being the worst pain imaginable) pain level at the head and both arms. Resident 1 sustained swelling of the left arm, scrapes on the right side of the face, abrasion on the right elbow, redness, swelling on both sides of the abdomen. Resident 1 was transferred to the General Acute Care Hospital (GACH 1) on 7/21/2025 and was readmitted back on the same day (7/21/2025) with abrasions (a superficial wound caused by rubbing or scraping away the skin's outer layers) to the elbow and contusions (medical term for a bruise) on the face. Findings: During a review of Resident 1's admission Record indicated the facility originally admitted Resident 1 on 6/18/2021 with a diagnosis which included thrombocytopenia (your blood does not clot well due to low levels of cells that help to stop bleeding by clumping together), muscle weakness, blindness, cerebral infarction ( blockage in a blood vessel that result in a section of brain tissue death). During a review of Resident 1's History and Physical (H&amp;P) dated 6/10/2024, the H&amp;P indicated Resident 1 has fluctuating capacity to understand and make decisions. During a review of Resident 1's care plan titled The Resident has an ADL Self Care performance Deficit related to his disease process of cerebral edema (swelling in the brain) dated 5/9/2025, the care plan indicated interventions to include mechanical lift transfer, being dependent with toilet hygiene, bed mobility, and personal hygiene. During a review of Resident 1's Order Summary Report dated 6/3/2025, the Report indicated Resident 1 had an order for a low air loss mattress [LAL]: monitor settings based on residents' weight and functional level every shift. During a review of Resident 1's record titled Lift Transfer Reposition dated 6/11/2025, indicated Resident 1 Required total lift, requiring two staff members for repositioning in bed. During a review of Resident 1's Minimum Data Set (MDS, standardized care and screening tool), dated 7/3/2025, indicated Resident 1 was assessed to be cognitively impaired (a term used when a person has certain limitations in mental functioning and in skills). The MDS also indicated Resident 1 was assessed as being dependent (helper does all of the effort, or the assistance of 2 or more helpers is required for the resident to complete the activity) while rolling to left and right and when transferring from chair to bed. During a review of Resident 1's Progress Notes titled SBAR [Situation, Background, Assessment, Recommendation] Summary documented on 7/21/2025, the SBAR indicated Resident 1 was observed laying on the floor at 6:10 AM (7/21/2025) on his left side facing the glass door and verbalized having head pain. The SBAR indicated Resident 1 was assisted back to bed with the assistance of three nurses and provided with wound treatment. The SBAR indicated 911 Emergency Services (EMS - refers to the system of healthcare professionals and resources that provide immediate medical care to individuals in emergency situations) was called and transferred Resident to GACH 1 on 7/21/2025. During a review of Resident 1's Interdisciplinary Care Conference dated 7/21/2025, the record </li></ol>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement the facility's infection control program to prevent, identify, report, investigate an infection outbreak (OB-an unusual increase of disease among a specific population in a geographic area during a specific period) for 9 out of 22 sampled residents (Resident 6, 7, 8, 9, 10, 11, 12, 13, 14) in accordance with the facility's policy and procedures and standard of professional practice. The facility failed to: 1. Identify scabies OB (an increased number of skin infection caused by infestation of the human itch mite that burrow under the skin where it lives and lays its eggs that can cause intense itching, especially at night, and a pimple-like rashes that spread through prolonged, direct skin-to-skin contact with an infected person) when Resident 6 was diagnosed with scabies on 7/23/2025 and when (Residents 7, 8, 9 and 10) were suspected and exhibited signs and symptoms consistent of scabies such as rashes and were treated with Permethrin 5% cream (a scabicide or a medication used to treat scabies) on 7/23/2025. 2. Report on 7/23/2025 the scabies OB to the local health department about the presence of a scabies OB in the facility when Resident 6 was clinically diagnosed at the General Acute Care Hospital (GACH) with scabies and five residents were suspected of scabies (Resident 7, 8, 9 and 10) on 7/23/2025. 3. Prevent the spread of infectious disease and rashes by failing to immediately place Residents 7, 8, 9 and 10 on 7/23/2025 who were suspected and exhibited signs and symptoms of scabies and Resident 11 who was exposed Resident 6 or on contact isolation or transmission-based precaution (contact precautions, an infection control measures used in healthcare settings to prevent the spread of germs that can be transmitted through direct or indirect contact with a patient or their environment). 4. Prevent the spread of infection by limiting the movement of Residents 13 and 14 within the facility who are on transmission-based precaution on 8/8/2025. 5. Prevent the spread of infectious disease by ensuring Resident 12 was placed on transmission-based precaution when suspected with scabies infection on 8/3/2025 and when the resident complained of rashes and itching was not resolved. 6. Conduct a surveillance and thorough investigation of residents with rashes and include in the Line Listing to tract and identify the root cause of residents with rashes and staff by identifying individual cases and trends. Residents 12, 13, 14, 15, 16, 17, 18 and 19 were not included in the line listings the facility provided 7/28/2025 as having rashes and suspected with scabies. 7. Ensure the Infection Prevention Nurse (IPN) or designee inform and educate all the facility staff, residents and visitors in direct contact with the residents about the scabies OB from 7/23/2025 to present (8/9/2025) to control further spread of infection. 8. Ensure the IPN educate the Restorative Nurse Assistant, Certified Nursing Assistant and Social Service Assistant and Receptionist) about transmission-based precautions who were in close contact with Residents 13 and 14 with rashes and suspected of scabies infection on 8/8/2025. 9. Ensure the Director of Nursing (DON), Administrator (ADM), Infection Prevention Nurse (IPN) and designee perform daily surveillance, monitor and evaluate the compliance of the staff, residents and visitors regarding infection control practices. 10. Conduct an oversight or surveillance of the staff when reporting to residents identified with rashes and verify the accuracy of the scabies OB line listings (a tool used to track and manage scabies outbreaks consisting of or suspected of infection or had closed contact with residents with infection) provided. 11. Ensure the Infection Prevention Nurse (IPN) and/or designee consistently conduct surveillance, track and monitor residents and staff with signs and symptoms of scabies infection during the scabies OB. 12. Establish a surveillance system that allows the facility to track, analyze and interpret the data, and identify a concern related to infection control. These deficient practices contributed to the ongoing transmission of scabies within the facility that resulted in a facility wide scabies OB that increased the residents' cases of 21 suspected scabies and one confirmed resident with scabies from 7/23/2025 to 8/9/2025 which placed the remaining 116 residents at risk for contracting scabies. Findings: A review of the facility's policy and procedure for Infection Control and Prevention indicates a resident(s) who is presented with a suspected or confirmed infection, illness or condition that is reportable, and that the administrator (or designee) is to notify the local health department. A suspected or confirmed outbreak within the facility is promptly identified and managed by ensuring the infection prevention control nurse and/or designee is to educate facility staff, visitors, residents, conduct surveillance, tracking and ensure transmission-based precautions are implemented. 1. During a review of Resident 6's Change in Condition (CoC) evaluation report, dated 1/13/2025, indicated Resident 6 had scattered erythematous papules (small red raised bumps on the skin) and self-inflicted excoriation to</p>		