

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 11/07/2025
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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that pain management was provided to one of three sampled residents (Resident 1), consistent with professional standards of practice and in accordance with its policy and procedure titled Pain Management. The facility failed to: 1. 1. Ensure Resident 1's pain was accurately assessed for the type, frequency, intensity, and duration of the pain, re-evaluate the effectiveness of the intervention to determine what increase or decrease in the frequency, intensity, duration of pain after the resident's fall on 7/28/2025. 2. 2. Ensure that Resident 1 was accurately assessed and evaluated for continued complaints of right leg pain and refusal to ambulate due to pain during Physical Therapy (exercise to promote, maintain, and restore physical movement and function) from 8/2025 to 9/2025. 3. 3. Inform the Nurse Practitioner (NP)1 or the Physician (MD)1 that Resident 1 had persistent right leg pain during ambulation and refused to participate in physical therapy exercises due to right leg pain on 8/5/2025, 8/11/2025, 8/29/2025, 8/30/2025, 9/8/2025 and 9/14/2025. These failures resulted in Resident 1's pain being poorly controlled that led to Resident 1's refusal to ambulate after the fall on 7/28/2025 and had the potential for complication due to pain and lack of mobility. Findings: A review of the facility's P&P titled, Pain Management, dated 8/25/2021, the P&P indicated the facility must maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. The P&P indicated Residents who receive pain interventions will be monitored for effectiveness and ineffectiveness of routine or PRN (as needed) medications including interventions, follow-up, and physician or advance practice provider (APP) notification. A review of the facility's P&P titled, Change in Condition: Notification of, dated 8/25/2021, the P&P indicated the facility must immediately inform the resident, the resident's primary care physician (PCP) or nurse practitioner (NP), and notify the resident representative, if the resident experienced a significant change in physical, mental, or psychosocial status. A review of Resident 1's admission Record (AR), the facility admitted Resident 1 on 7/31/2020 and readmitted on [DATE] with diagnoses that included a nondisplaced fracture (broken bone) of lateral malleolus of right fibula (right ankle), initial encounter for closed fracture, and other specified disorder of bone density and structure, right lower leg. A review of Resident 1's History and Physical (H&P), dated 1/21/2025, the HP indicated Resident 1 had fluctuating capacity to understand and make decisions. A review of Resident 1's Change in Condition Evaluation (CoC), dated 7/28/2025 timed at 6:31 PM, the CoC indicated Resident 1 was found on the floor with her head on the pillow. The CoC indicated Resident 1 stated, she pulled herself to the side and rolled off the bed. A review of Resident 1's clinical record indicated an Xray of the hips and knees was completed on 7/28/2025 which did not show any fracture on the first X-ray performed (the first Xray performed). A review of Resident 1's PT evaluation, dated 7/30/2025 timed at 4:24 PM, the evaluation indicated Resident 1 required encouragement to participate in gait (a person's pattern of walking) training due to fear of fall. A review of Resident 1's PT Encounter Note, date of service 8/5/2025, the Encounter Note indicated Resident 1 complained of slight right ankle pain after standing for too long with bruising and minimal swelling from a previous fall (fall on 7/28/2025). The Encounter Note indicated Resident 1 PT was deferred ambulation due to Resident 1's pain and safety. A review of the MAR and the PN indicated Resident 1 had zero pain level and did not receive any pain medication 8/5/2025. There was no documented evidence PT informed the licensed nurse about Resident 1's bruising and swelling on the ankle and that ambulation was deferred. A review of Resident 1's Radiology report, examination dated 8/7/2025 timed at 6:45 AM and a reported date of 8/8/2025 timed at 1:46 PM, the report indicated Resident 1 had a right ankle fracture of an uncertain age. A review of Resident 1's PT Encounter Notes, date of service 8/7/2025, the Encounter Note indicated Resident 1 continued to complain of pain. A review of the MAR indicated Resident 1 had zero pain level and did not receive any pain medication. A review of the NPN indicated 8/7/2025 at 11 AM, PT reported while attempting to get up to walk resident complained of right ankle pain when standing. A review of Resident 1's NPN, dated 8/8/2025 timed at 8:13 AM, indicated the Primary Care Physician (PCP) 1 was notified Resident 1's right ankle radiology reports and ordered for Resident 1 not to walk or put weight on the right ankle. The PN indicated PCP 1 will be visiting [Resident 1] within the next week. A review of the MAR indicated on 8/9/2025 at 9:20 AM, Resident 1 received Tylenol 500 milligrams (mg) one tablet for right foot pain at 5/10 pain level (0 no pain and 10-severe pain scale). A review of the NPN dated 8/9/2025 timed at 1:38 PM indicated Resident 1 was medicated for pain as ordered with effect. The NPN further indicated the licensed nurse left a message to</p>		