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	11/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to treat residents with dignity and respect for 2 of 3 sampled residents (Resident 3 and Resident 4) reviewed for resident's rights by failing to: 1. Ensure timely staff response after Resident 3 activated the call light. Resident 3, who is cognitively intact but physically dependent on staff for all activities of daily living (ADL), was observed waiting at least 19 minutes for assistance after pressing the call light on 9/16/2025. During this time, facility staff were observed standing at the Nurses' Station while the call light remained illuminated. Resident 3 reported frequent delays in staff response-sometimes waiting up to an hour-and stated that he often had to rely on his roommate to leave the room to seek help. This delay, combined with the resident's report of frequent prolonged waits, demonstrates a lack of respect for the resident's dignity and needs and compromised the resident's physical safety. 2. Ensure respectful communication and appropriate follow-up for Resident 4 after he reported that CNA 1 used derogatory language. On 9/1/2025, Resident 4 stated that after requesting hot water, CNA 1 allegedly responded, stupid old man, and, when confronted, said, I don't care. As a result, Resident 4 verbalized that he felt disrespected and neglected. This deficient practice had the potential to cause further emotional distress, unmet care needs, and a diminished sense of dignity and well-being. Resident 4 further stated that, following the incident, he felt CNA 1 no longer acknowledged or assisted him when assigned to his care on 9/15/2025. Findings: 1. During a review of the facility's Policy and Procedure (P&P) Answering the call light, with a revision date of 10/24/2024, the P&P indicated the following information: The purpose of this procedure is to ensure timely response to the resident's requests and needs. During a review of Resident 3's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE]. The AR indicated the resident's diagnoses including paralytic syndrome following cerebral infarction (weakness or the inability to move on one side of the body following a stroke) and quadriplegia (paralysis that results in the loss of movement and sensation in all four limbs). During a review of Resident 3's Care Plan, developed on 1/20/2016 and revised on 12/26/2018, the Care Plan identified the resident as at risk for falls and injury, with interventions including ensuring the call light was within reach. During a review of Resident 3's Care Plan, revised on 5/09/2025, the care plan included goals to anticipate and meet ADL needs to maintain the highest practicable level of functioning. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Minimum Data Set (MDS) dated [DATE] indicated that Resident 3 was cognitively intact and fully dependent on staff for ADLs that included toileting, bathing, dressing, and transfers. During an observation inside Resident 3's room on 9/16/2025 at 12:03 PM, Resident 3 was observed in a wheelchair next to his bed, pressing the call light to request assistance with retrieving personal belongings from his bedside drawer. The call light was illuminated on the back wall behind the bed and outside the room above of the doorway. During a concurrent interview, Resident 3 stated I don't expect anyone to come soon. Sometimes it takes up to an hour. I have to ask my roommate or go outside to get help because staff do not come when I need to get back to bed or assistance to reach my things. During the same observation on 9/16/2025 at 12:22 PM (19 minutes later), the call light in Resident 3's room was still illuminated outside the room. CNA 6 was observed walking the facility hallway by Resident 3's room, toward Nursing Station 4. When interviewed, CNA 6 confirmed that Resident 3's call light was visible outside the room and should be heard at Nursing Station 4. CNA 6 stated she was coming back from her meal break and was going to check what Resident 3 needed. During a concurrent observation on 9/16/2025 at 12:23 PM in the presence of CNA 6, Resident 3's room call light was observed illuminated and heard at Nursing Station 4. There were three facility staff present at Nursing Station 4, the Assistant Director of Nursing (ADON 2), Licensed Vocational Nurse (LVN) 5 and Registered Nurse (RN) 1. CNA 6 stated that another CNA (CNA 5) was supposed to cover her assignments while on break. During the concurrent observation and interview, ADON 2 walked out of Nursing Station 4, LVN 5 and RN 1 stated they did not notice the Resident 3's call light was on and thought it was from another Nursing Station. LVN 5 stated they should have answered Resident 3's call light. During an interview on 9/16/2025 at 12:35 PM with CNA 5, CNA 5 stated she was supposed to be covering for CNA 6 while she was on break. CNA 5 stated she had not answered or heard Resident 3's call light because she was busy assisting another resident inside their room and thought the other facility staff at Nursing Station 4 would answer the residents' call lights. During an interview on 9/16/2025 at 12:46 PM with Resident 3's room mate (Resident 4), Resident 4 stated he had witnessed multiple occasions when Resident 3 needed staff's assistance to go to the restroom, get in or out of bed but the facility staff would not come to assist Resident 3 despite pressing the call light and waiting for a while. Resident 4 stated there have been times when Resident 3 had to wait for over 30 minutes from pressing the call light. Resident 4 stated no one from the facility would come by the room to answer the call light. Resident 4 had to go out of their room in his wheelchair to look for facility staff to come and assist his roommate Resident 3. During an interview on 9/17/2025 at 12:38 PM, with ADON 1, ADON 1 stated resident call lights should be answered in a timely manner time by any facility staff within 5 minutes. ADON 1 stated anyone can answer the call light and endorse to a specific staff (licensed or unlicensed) accordingly depending on the resident's specific needs. ADON 1 stated ADON 2, RN 1 and LVN 5 should have answered or responded to Resident 3's call light when they heard the call light in Nursing Station 4. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of the facility's P&P titled Quality of Life – Dignity, dated 2/2021, the P&P indicated that residents must always be treated with dignity and respect. The P&P further indicated that staff should always speak respectfully to residents. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 1/30/2025 with diagnoses including orthopedic aftercare following surgical amputation (surgical removal of a limb) and acquired absence of left leg above knee). During a review of Resident 4's History and Physical (H&P), dated 1/30/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills were intact. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet documents, the document indicated the following information -For 8/31/2025, the document indicated CNA 1 worked the 11 PM to 7 AM shift and was assigned to provide care for Resident 4. -For 9/9/2025, the document indicated CNA 1 worked the 11 PM to 7 AM shift and was assigned to provide care to Resident 4. During a review of Resident 4's Change of Condition (CoC) evaluation, dated 9/9/2025, the CoC indicated that Resident 4 overheard an unknown person speaking about someone in the hallway during the 11 PM to 7 AM shift. However, Resident 4 could not recall the exact date or time. The CoC further indicated that Resident 4 could not clearly hear the comments but believed they might have been directed at him. During a review of Resident 4's Care Plan (CP), dated 9/9/2025, the care plan indicated Resident 4 believed he overheard an unknown staff member talking about him in the hallway. The CP interventions included 72-hour monitoring and to follow facility protocols. During a review of a typed statement by Staff Scheduler (Scheduler) 1, dated 9/9/2025, the statement indicated that Scheduler 1 assisted in translating for the Administrator (ADM) and Resident 4, who spoke a foreign language. The statement noted that Resident 4 overheard an unknown person's voice in the hallway at an unspecified date and time and was unsure whether the voice was referring to him. Resident 4 identified the voice as belonging to a specific gender and mentioned several names that rhymed with CNA 1's name. During a review of Resident 4's record titled Interdisciplinary Care Conference (IDT), dated 9/10/2025, the IDT indicated there was a concern for Alleged abuse. The IDT's recommendations included monitoring Resident 4 for emotional distress every shift, monitor for episodes of hearing anything distressful, and for a psychiatrist consult. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's 5-day letter (facility investigation summary/conclusion), dated 9/11/2025, the letter indicated that Resident 4 overheard an unidentified CNA in the hallway say something like stupid old man. However, Resident 4 was unsure whether he heard the comment correctly or if it was directed at him. The letter stated that Resident 4 later speculated that his CNA that night may have been [CNA 2] but clarified that he liked this CNA (CNA 2) and had no concerns about him and wanted him to continue to be assigned to Resident 4. The letter further indicated that Resident 4 did not believe it was [CNA 2] who made the comment but acknowledged that [CNA 2] was assigned to him the night [undated] the incident occurred. Resident 4 did not believe the incident constituted abuse or neglect but requested that staff be mindful of conversations in the hallway. During a review of the Nursing Staffing Assignment and Sign-in Sheet document, dated 9/15/2025, the document indicated CNA 1 worked during the 11 PM to 7 AM shift and was again assigned to provide care for Resident 4. During an observation and interview on 9/16/2025 at 12:31 PM in Resident 4's room, Resident 4 stated, the incident happened specifically on 9/1/2025 sometime after 12 midnight (11 PM to 7 AM shift). Resident 4 stated, he asked [CNA 1] for hot water from the kitchen and not the sink, and he heard [CNA 1] said stupid old man. Resident 4 stated, he told [CNA 1] not to say that, and CNA 1 responded I don't care. Resident 4 stated that he informed a Licensed Vocational Nurse (LVN) that same night, but he was unable to recall the name of the LVN. Resident 4 stated, [CNA 1] had a specific height, had a specific hairstyle, and worked on that specific shift (11 PM – 7 AM). Resident 4 stated, [CNA 1] worked the previous night (9/15/2025) and recognized [CNA 1] when [CNA 1] came into his room to care for Resident 4's roommate. Resident 4 stated that [CNA 1] walked by his bed without acknowledging Resident 4 and had to call out to [CNA 1] to empty out his urinal bottle (portable container used to collect urine). During a telephone interview on 9/16/2025 at 3:54 PM with CNA 1, CNA 1 stated that he was assigned to care for Resident 4 during the nightshift [1 PM to 7 AM] of 8/31/2025. CNA 1 stated, Resident 4 asked for hot water, and CNA 1 went to the breakroom to heat up the water in the microwave water. CNA 1 stated, he remembered Resident 4 thinking the hot water was from the sink faucet. CNA 1 stated that he had asked LVN 3 to tell Resident 4 the hot water was taken from the Nursing Station and not the sink. During a concurrent interview and record review on 9/17/2025 at 11:20 AM with the ADM, CNA 2's employee file and 5-day letter were reviewed. The ADM stated, she had a telephone interview with CNA 2 on 9/10/2025 at 9:10 PM. The ADM stated CNA 2 denied speaking in a disrespectful manner towards Resident 1. During another interview on 9/17/2025 at 1:50 PM with Resident 4, Resident 4 stated, that on 9/1/2025 when CNA 1 called him stupid old man, he felt disrespected. Resident 4 stated he wanted CNA 1 to respect him as a resident. Resident 4 stated he felt something had changed in the way CNA 1 cares for him. Resident 4 stated, currently CNA 1 would come into his room to care for his roommate, but CNA 1 does not help him [Resident 4] anymore and felt neglected. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/17/2025 at 3:25 PM with the ADM, Resident 4's CoC, dated 9/9/2025, and the SS Progress Notes, date 9/9/2025, were reviewed. The ADM stated according to the CoC, Resident 4 could not provide the name of the person who made the comment against Resident 4. The ADM stated, Resident 4 described the unknown person as a CNA with the specified gender, specified height, and the first letter of the first name. However, the ADM stated that the CoC did not document about the specific gender, height, or specific first letter of the alleged person's name, written in the CoC. The ADM stated the description of the alleged person was in the verbal statement of the CNA (Scheduler 1) who helped translate Resident 4's interview. During an interview on 9/17/2025 at 3:28 PM with the ADM, the ADM stated that CNA 2 did not receive a one-on-one in-service about the allegation of Resident 4 and abuse in-service upon returning to work. The ADM stated, there was no documented evidence that she reviewed the facility's Abuse policy and procedure with CNA 2 over the phone on 9/10/2025 at 9:10 PM, during the interview. During a concurrent interview and record review of the facility's P&P titled Quality of Life – Dignity, dated 2/2021, on 9/17/2025 at 3:45 PM with the ADM. The ADM stated that it is not appropriate for any staff to say derogatory names to residents such as stupid old man. During an interview on 9/18/2025 at 9:22 AM with Scheduler 1, Scheduler 1 stated that she assisted in translating a foreign language for the Administrator (ADM) and Resident 4 on 9/9/2025. Scheduler 1 reported that Resident 4 stated that he overheard an unknown CNA in the hallway say, this old man. Resident 4 also provided possible names and mentioned a name that was very close to CNA 2's name, as well as CNA 1's name and described the CNA's height and gender. Scheduler 1 stated that Resident 4 described the CNA's comment as disrespectful and noted that there was no prior situation that might have prompted the CNA's remark.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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, in accordance with the facility's policy and procedure (P&P) titled Care Plan Comprehensive, for 1 of 3 sampled residents (Resident 2) reviewed for comprehensive care plans. The facility failed to: Develop and implement a comprehensive person centered care plan to address Resident 2's inappropriate physical contact with other residents and clearly define the behaviors to be monitored during one-to-one (one-to-one) supervision; 2. Consistently implement the one-to-one supervision as outlined in Resident 2's care plan until it could be modified or discontinued. These deficient practices had the potential to result in Resident 2 not receiving the supervision necessary to ensure his safety and well-being. Additionally, the failure to implement the care plan interventions could compromise Resident 2's medical, physical, mental, and psychosocial health, and prevent him from attaining or maintaining his highest practicable level of functioning. Findings: During a review of the facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the facility must develop and implement a comprehensive person-centered CP for each resident to meet the resident's medical, physical, mental, and psychosocial needs. During a review of the facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the CP must included 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 Resident 1's admission Records (AR), the AR indicated the facility admitted Resident 1 on 4/22/2008 and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting the right dominant side, contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right hand and shoulder, and expressive language disorder (communication difficulty where a resident has trouble using words to express thoughts, ideas, or messages even though the resident can understand spoken or written language). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/11/2025, the MDS indicated Resident 1 cognitive (a resident's mental process of thinking, learning, remembering, and using judgement) skills were intact. The MDS indicated Resident 1 required maximal to moderate assistance with Activities of Daily Living. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 4/26/2017 and readmitted Resident 2 on 1/13/2025 with diagnoses that included peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), complete traumatic amputation (surgical removal of a limb) at level between left and right hip and knee, and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills were impaired. The MDS indicated Resident 2 required moderate assistance for ADLs. During a review of Resident 1's Change of Condition (CoC) evaluation, dated 9/8/2025 timed at 2:00 PM, the CoC indicated Resident 1 claimed Resident 2 tickled the back of her neck with a plastic wrapper. The CoC indicated Resident 1 told Resident 2 to stop. During a review of Resident 2's CoC evaluation, dated 9/8/2025 timed at 2 PM, the CoC indicated Resident 2 had an inappropriate behavior towards another resident. During a review of Resident 2's care plan (CP), dated 9/8/2025, it was noted that Resident 2 exhibited inappropriate behavior toward other residents, including an allegation that he tickled a resident. The care plan indicated that Resident 2 was placed on one-to-one supervision and that staff were to monitor him for episodes of inappropriate touching. The care plan did not indicate specific behaviors to monitor and resident centered interventions for the facility staff to monitor during one-to one supervision and the duration or evaluation when to stop. During a review of Resident 2's Order Summary Report, the active order, dated 9/8/2025, indicated Resident 2 was placed on one-to-one monitoring. During a review of Resident 2's Interdisciplinary Care Conference (IDT), dated 9/9/2025 timed at 2:41 PM, the IDT recommended for a one-to-one sitter for monitoring behavior. During an observation and interview on 9/16/2025 at 1one-to-one 0 AM in Resident 1's room, Resident 1 stated that she was in the lobby listening to music when Resident 2 touched the back of her neck with a plastic wrapper on Monday, 9/8/2025. Resident 1 stated that approximately 25 minutes after the first incident, while she was on the phone, Resident 2 touched the back of her neck again. Resident 1 reported that she told Resident 2 to get out of here and go. Resident 1 also stated that Resident 2 had a facility staff watching him all day and night on 9/8/2025 and all day on 9/9/2025, but not after 9/9/2025. Resident 1 further reported that Resident 2

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews and record reviews, the facility failed to ensure that accurate and current nurse staffing data [total number and actual hours worked by licensed (Registered Nurses [RNs], License Vocational Nurses [LVNs]) and unlicensed nurses (Certified Nursing Assistant [CNAs])] were posted daily at the beginning of each shift (11 PM - 7 AM, 7 AM - 3 PM, and 3 PM - 11 PM). These deficient practices of posting inaccurate and outdated nurse staffing data had the potential to mislead and prevent residents and families from verifying the facility's daily staffing levels. This could result in distrust and a perceived lack of accountability in maintaining accurate and adequate staffing necessary for timely resident care. Findings: During a review of the facility's Policy and Procedure (P&P) Posting Direct Care Daily Staffing Number, with a revision date of August 2022, the P&P indicated the following information: -The P&P indicated that within two hours of the beginning of each shift, the number of licensed nurses (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for the resident care is posted in a prominent location (accessible to residents and visitors) and in clear and readable format. -The P&P further indicated that the information recorded on the form must include among other details The actual time worked during that shift for each category and type of nursing staff. During an observation on 9/16/2025 at 9:30 AM, an untitled facility document dated 9/11/2025 (5 days prior to observation date) was observed posted in the facility's front lobby. The document posted in the front lobby indicated the Facility Census was 112. The facility document indicated the nursing staffing information according to licensed nurses and unlicensed nurses per category (RNs, LVNs, CNAs, Desk Nurse, etc.) directly responsible for resident care each shift (11 PM-7 AM, 7 AM-3 PM, 3 PM-11 PM). However, the document indicated the staffing information posted was the facility's daily projected nursing hours for licensed and unlicensed nursing hours for 9/11/2025. The document did not indicate the actual time worked on 9/11/2025, for each category and type of nursing staff. During a concurrent interview and record review on 9/16/2025 at 9:30 AM with the Administrator (ADM), the ADM stated the facility Director of Staff Development (DSD) was out on leave since 9/27/2025 and in charge of updating and posting and filing the nursing staffing data by the facility's front lobby. The ADM stated she had not noticed that the nurse staffing data posted had not been updated since 9/11/2025. During another interview on 9/16/2025 at 4:40 PM with the ADM, the ADM stated there was no other staff member specifically assigned to the responsibility to ensure the daily posting of nurse staffing data was updated daily each shift. The ADM stated since the DSD had gone on leave of absence, the ADM created her own staffing posting document to display the projected staffing hours at the facility lobby and not the actual time worked each shift.