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	12/08/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 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 interview and record reviews, the facility failed to ensure the resident's responsible party (RP) was informed and participated in the plan of care meetings for one of three sampled residents (Resident 1) reviewed for pressure ulcers and developed a Stage 4 pressure ulcer (a skin damage resulting from prolonged unrelieved pressure that is very deep, open sore to the skin tissue down to the muscle, bone, or tendon) in the facility. This deficient practice violated the residents' rights to be an active participant and be fully informed of Resident 1's care. Findings: A review of the facility's policy and procedure (P&P) titled Skin Integrity Management dated 5/26/2021, the P&P indicated to Notify patient, resident representative of plan of care. Review care plan and revise as indicated. A review of the facility's P&P titled Care Plan Comprehensive dated 8/25/2021, the P&P indicated The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment. A review of the facility's P&P titled Nursing Documentation dated 6/27/2022, the P&P indicated Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's condition, situation, and complexity. A review of Resident 1's admission Record (AR) indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included pressure ulcer of sacral region - stage four (a severe deep wound in the sacral [lower back] area where the skin, fat, and even underlying muscle or bone have been destroyed), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and tracheostomy status (a surgical procedure that creased a direct opening in the neck into the windpipe to help a person breathe). A review of Resident 1's History and Physical (H&P) dated 8/25/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/10/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had one or more unhealed pressure ulcers/injuries. A review of Resident 1's Order Audit Report dated 9/14/2025 at 12:34 PM, indicated an order for Sacrococcyx bilateral (both sides) buttocks: clean the affected area using normal saline (NS, a sterile, medical-grade saltwater solution), gently pat dry, apply collagen powder (supplement made from hydrolyzed collagen, which was broken down, smaller pieces of the body's most abundant protein, collagen) then cover the area with calcium alginate (a natural fiber from brown seaweed that was used to make absorbent wound dressings) and cover with a dry dressing every shift for pressure injury (a sore that developed from prolonged pressure on the skin, which restricted blood flow and damaged the underlying tissue) for 30 days, monitor for signs and symptoms of infection and as needed. A review of Resident 1's Interdisciplinary Care Conference - Skin Alterations dated 10/14/2025 at 12:05 AM, indicated attendees included the Registered Nurse Supervisor (RNS), Licensed Vocational Nurse (LVN), Treatment Nurse (TN), Registered Dietician (RD), and the Residents Representative. The Interdisciplinary Care Conference indicated the resident had a stage four wound of the Sacrococcyx extending to bilateral buttocks (tailbone [coccyx] and the triangular bone directly above [sacrum] spread to both of the fleshy areas of the buttocks) measuring 7.2 centimeters (cm, a metric unit of length) in length, 5.4 cm in width, and 0.7 cm in depth. The Interdisciplinary Care Conference indicated the resident's stage four wound was improving. A review of Resident 1's Sacrococcyx Stage Four Care Plan dated 6/16/2025, indicated resident's wound was healing as evidenced by a decrease in size, absence of erythema (redness and inflammation) and drainage, and/or presence of granulation. The Care Plan indicated a maintenance goal for the wound to remain free from signs and symptoms of infection with the interventions to provide resident and/or healthcare decision maker education regarding risk factors and interventions, assist resident in turning and reposition every two hours, and weekly wound assessment that included measurements and description of wound status. During an interview on 10/20/2025 at 10:11 AM, the Resident's Responsible Party (RP) stated the facility informed the RP that Resident 1's wound had re-opened but the facility never stated the stage of the wound or the measurements. The RP stated the facility staff have never talked to her about the resident's wound specifically. During an interview on 10/21/2025 at 12:51 PM, the RP stated care conferences with the facility

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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. (continued on next page)

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F 0755 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 interviews and record reviews, the facility failed to administer nystatin (a skin cream with a specific dose of medicine that was used to treat fungal infections), Zoryve (Roflumllast, a prescription medication, in the form of a cream or foam that treated inflammatory skin conditions reducing inflammation instead of using steroids), and normal saline (NS, a sterile, medical-grade saltwater solution) medications as ordered by the physician for one of three sampled residents reviewed for medication and treatments administration (Resident 2). As a result, Resident 2 did not receive his scheduled wound medication and treatment which could have resulted in the resident's wound worsening and the peripherally inserted central catheter (PICC, a long, thin tube inserted into a vein in our upper arm that extended to a large vein near your heart) to become occluded (stop, close up, or obstruct an opening). Findings: A review of the facility's undated policy and procedure (P&P) titled, Administering Medications, the P&P indicated Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. A review of Resident 2's admission Record (AR) indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included epileptic seizures (chronic neurological disorder characterized by recurrent, unprovoked seizures [temporary event caused by a sudden surge of abnormal electrical activity in the brain]), pressure ulcer of sacral region (a shallow, open sore on the skin over the tailbone) and chronic kidney disease (a long-term condition where the kidney gradually lost their ability to filter waste products form the blood and maintain fluid balance). A review of Resident 2's History and Physical (H&P) dated 5/7/2025 indicated the resident had fluctuating capacity to understand and make decisions. A review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 10/17/2025 indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 2 had one or more unhealed pressure ulcers/injuries. A review of Resident 2's Physician's Order dated 8/28/2025 at 4:39 AM, indicated an order for nystatin external cream 100,000 unit/gram, apply to right ischium (the lower, back part of the hip bone) peri area (the surrounding tissue, including muscles, nerves, fat-filled spaces, and ligaments that attach to or pass near the right ischium) topically every day shift for redness, cleanse with NS, pat dry, apply cream to surrounding area after open wound cleansing and cover with foam dressing (a soft, absorbent pad made of foam that was used to cover and protect wounds). A review of Resident 2's Physician's Order dated 8/28/2025 at 4:39 AM, indicated an order for nystatin external cream 100,000 unit/gram, apply to Sacrococcyx (the region at the very bottom of your spine where the sacrum [triangular bone] and the coccyx [the tail-bone] meet) peri area topically every day shift for redness, cleanse with NS, pat dry, apply cream to surrounding area after open wound cleansing and cover with foam dressing. A review of Resident 2's Physician's Order dated 8/28/2025 at 4:39 AM, indicated an order for Zoryve external foam 0.3 %, apply to scalp, face, chest topically one time a day for seborrheic dermatitis (a common, non-contagious skin condition causing red, flaky, and greasy patches, most often on oily areas like the scalp, face, chest, and ears). A review of Resident 2's Physician's Order dated 8/28/2025 at 4:39 AM, indicated an order for NS flush intravenous (IV, within a vein) solution 0.9% (Sodium chloride flush, a small injection of sterile saltwater use to clean out an IV), use 10 milliliters (ml, unit of measurement) intravenously every 12 hours for PICC line maintenance. A review of Resident 2's Treatment Administration Record (TAR) dated 10/1/2025 to 10/31/2025, indicated there was no documentation that the resident received nystatin external cream 100,000 unit/gm on 10/15/2025 and 10/16/2025. A review of Resident 2's TAR dated 10/1/2025 to 10/31/2025, indicated there was no documentation that the resident received Zoryve external foam from 10/6/2025 to 10/9/2025 (four days) and from 10/13/2025 to 10/17/2025 (five days) for a total of nine days. A review of Resident 2's IV Administration Record dated 10/1/2025 to 10/31/2025, indicated there was no documentation that the resident received NS flush on 10/6/2025 and 10/19/2025. During an interview on 10/20/2025 at 3:21 PM, Resident 2 stated he had not received his cream medications that was for his skin. Resident 2 stated when he did not receive the medication, he felt hot and dehydrated which did not make him feel good. During a concurrent interview and record review of Resident 2's TAR on 10/21/2025 at 1:36 PM, Licensed Vocational Nurse (LVN) 1 stated the resident's nystatin external cream should have been administered daily and that the TAR should not be blank, indicating no documentation that nystatin was administered. LVN 1 stated if there was no

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 interview and record review the facility failed to maintain current detailed and consistent medical records readily available for one of three sampled residents reviewed for documentation (Resident 1), who did not have a documented evidence of turning and repositioning every two hours to prevent worsened pressure ulcer (skin injury resulting from prolonged unrelieved pressure on the skin) in accordance with the physician's order to turn resident on the side every two hours, document and chart in the folder at bedside, every shift for wound healing. This deficient practice had the potential to have a negative impact on the residents' healing process and for Resident 1's wound to worsen. Findings: A review of the facility's undated policy and procedure (P&P) titled Turning a Resident on His/Her Side Away From You, the P&P indicated The purposes of this procedure was to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment. The P&P indicated The following information should be recorded in the resident's medical record: 1. The date and time that care was given. 2. The name and title of the individual(s) who assisted with the care. 3. The position in which the resident was placed. 4. The reason for changing the resident's position. 5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment, the reason(s) why and the intervention taken. 8. The signature and title of the person recording the data. A review of Resident 1's admission Record (AR) indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included stage four pressure ulcer of right buttock (a severe, open wound that had extended through the skin and into the underlying muscle, tendon, or even bone), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and tracheostomy status (a surgical procedure that creased a direct opening in the neck into the windpipe to help a person breathe). A review of Resident 1's History and Physical (H&P) dated 8/25/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/10/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had one or more unhealed pressure ulcers/injuries. A review of Resident 1's Order Summary Report dated 10/11/2025, indicated an order to turn resident on the side every two hours, document and chart in the folder at bedside, every shift for wound healing. A review of Resident 1's Treatment Administration Record TAR) dated 10/1/2025 to 10/31/2025, indicated to turn resident on the side every two hours, document and chart in folder at bedside, every shift for wound healing. The TAR indicated the facility staff documented every shift. A review of Resident 1's Turn and Reposition Every 2 Hours Document dated 10/12/2025 to 10/21/2025, indicated a time slot for every two hours from 12 AM to 10 PM and a space for the Certified Nursing Assistant (CNA) and Nurse to sign. The Document indicated on:1. 10/12/2025 - the CNA did not document at 6 AM. The LVN did not document at 6 PM.2. 10/13/2025 - the CNA did not document from 4 PM to 10 PM. The LVN did not document from 12 PM to 10 PM.3. 10/14/2025 - the CNA did not document from 12 AM to 6 AM and from 4 PM to 10 PM. The LVN did not document from 12 AM to 10 PM.4. 10/15/2025 - the CNA did not document from 12 AM to 6 AM. The LVN did not document from 12 AM to 4 PM.5. 10/16/2025 - the CNA did not document at 6 AM. The LVN did not document from 8 AM to 6 PM.6. 10/18/2025 - the CNA did not document at 6 AM and from 6 PM to 10 PM.7. 10/19/2025 - the LVN did not document at 10 PM. During a concurrent telephone interview and record review of Resident 1's Turn and Reposition Every 2 Hours Document on 10/23/2025 at 12:41 PM, the RNS stated the CNA and Nurse should have been documenting Resident 1's turning and repositioning every two hours. The RNS stated the facility staff also document on the computer system but the information should have reflected the same. The RNS stated there were gaps in the documentation, and if the CNA or Nurse did not document their signature then the resident was not being turned or repositioned. The RNS stated the reason the facility staff turn and reposition the resident was to relieve pressure and improve the wound and if Resident 1 was not turned or repositioned, the resident's wound would get worse.