

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 12/23/2025
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557</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 interview and record review, the facility failed to treat one of three sampled residents (Resident 2) with respect and dignity when Certified Nursing Assistant (CNA) 2 and 3 made derogatory (offensive and disrespectful) comments around Resident 2 while CNA's 2 and 3 were assisting Registered Nurse (RN) 1 perform disimpaction (the manual removal of hardened stool from the rectum using a gloved, lubricated finger, usually performed when severe constipation or fecal impaction cannot be relieved by other methods) procedure on Resident 2. This deficient practice resulted in the violation of the resident's rights for Resident 2 who reported feeling uncomfortable, upset and yelling at the staff, which could significantly compromise Resident 2's psychosocial well-being. Findings: During a review of the facility's Policy and Procedure (P&P) titled Resident Rights, dated December 2021, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence. [to] be treated with respect, kindness, and dignity. During a review of the facility's P&P titled Quality of Life - Dignity, dated February 2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. During a review of Resident 2's admission Record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs and arms), anxiety, and depression. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 10/3/2025, the MDS indicated Resident 2 was cognitively intact (having normal mental function, including memory, understanding, and decision-making, without significant impairment) and was fully dependent on staff (helper does all of the effort) for all cares and mobility such as rolling left and right in bed. The MDS further indicated Resident 2 was incontinent of bowel (involuntary loss of control over passing stool). During a review of Resident 2's Care Plan (CP) dated 8/23/2023, the CP indicated, Resident is incontinent of bowel and is unable to physically participate in a retraining program due to quadriplegia with a goal to have incontinence care need met by staff to maintain dignity and comfort. During another review of Resident 2's CP dated 12/20/2025, the CP indicated Resident reported CNA from 3 [PM] - 11 [PM] shift on 12/18/25 made a sexual inappropriate comment. During a review of Resident 2's Order Summary Report (OSR- a list of instructions from a licensed medical provider that authorize specific treatments, tests, medications, or services for a resident, serving as the legal and clinical basis for delivering care) dated 12/23/2025, the OSR indicated the following order: Resident may have bowel disimpaction management if BM (bowel movement - stool) [medications] are ineffective. every 24 hours as needed. During an interview with CNA 2 on 12/23/2025 at 9:52 AM, CNA 2 reported that on 12/18/2025, she assisted Registered Nurse (RN) 1 with Resident 2's fecal disimpaction. CNA 2 stated that prior to the procedure, RN 1 left the room to retrieve lubricant (a liquid agent used to reduce friction) and during that time, she engaged in a personal conversation with CNA 3 while inside Resident 2's room. During an interview with Resident 2 on 12/23/2025 at 10:05 AM, Resident 2 stated that on 12/18/2025, RN 1 and CNA 2 were performing fecal disimpaction on him (Resident 2). When RN 1 left the room to obtain lubricant, Resident 1 heard CNA 2 say aloud, What if you spit on it? Resident 2 stated that the comment made him feel uncomfortable and upset, which led him to yell at the staff. During an interview with CNA 3 on 12/23/2025 at 11:26 AM, CNA 3 stated that on 12/18/2025, she and CNA 2 were joking and discussing personal matters while waiting for RN 1 to return to Resident 2's room with lubricant. CNA 3 reported that she said, You can either hit it or quit it, to which CNA 2 responded, What if you spit on it? and laughed loudly. CNA 3 stated that Resident 2 appeared visibly upset upon hearing their conversation and began yelling at the staff. During an interview with the Director of Nursing (DON) on 12/23/2025 at 2:16 PM, the DON stated that inappropriate comments, such as those made by CNA 2, could be perceived as hurtful and offensive and may result in psychosocial harm. The DON emphasized that staff were expected to demonstrate mutual respect toward residents and uphold their basic human dignity at all times.</p>		