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 04/24/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement safety protocols, provide adequate supervision, and ensure effective monitoring to prevent the elopement of Resident 1. On 4/23/2026, at approximately 2:31 AM, Resident 1 exited the facility without staff knowledge and supervision. The resident remained missing until approximately 5:30-6 AM (approximately 3.5 hours later), at which time Resident 1 was located at a nearby bus stop, and was taken to the local general acute hospital (GACH). Additionally, the facility failed to complete a Leave of Absence without Notice assessment at the time of R1's admission to the facility, as required by facility policy. This failure resulted in Resident 1 having successfully eloped from facility and had the potential to lead to endangerment, accident and injury while outside the facility's premises without supervision from staff.Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (condition when the heart is too weak or working too hard to pump enough blood to the body, causing blood to back up) type 2 diabetes mellitus (DM, a health condition where the body cannot properly use sugar for energy, causing too much of it to build up in the blood), abnormalities of gait and mobility, acquired absence of right great toe, and other right toes. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 1's cognition was moderately impaired (the individual has some memory issues, disorientation, or confusion regarding daily tasks). The MDS indicated Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) in sit to stand activity and walk 50 feet with two turns. The MDS indicated Resident 1 had not exhibited wandering behavior. During a review of Resident 1's Care Plan dated from 4/1/2026 to 4/23/2026, there was no indication that an elopement care plan was initiated. Further review of R1's record lacked an elopement assessment and a Leave of Absence without Notice assessment. During a review of Resident 1's NPN, dated 4/23/2026 documented by RN 1 at 2:31 AM, the NPN indicated Resident1 was last seen at 2:31 AM., RN 1 initiated Code pink and search the facility but was unable to locate the resident. RN 1 continued to search the parking lot, nearby stores, and neighborhood. Facility staff informed the DON and the administrator as well as local law enforcement. During further review of the NPN, at 2:57 AM, RN 1 notified Resident 1's family and the physician that the resident was missing. During a review of Resident 1's SBAR (Situation, Background, Assessment, and Recommendation - a structured communication framework to convey critical patient information concisely) Summary for Providers, dated 4/23/2026, the SBAR indicated Resident 1 eloped from the facility at 2:20 AM via foot, wheelchair found left behind at front door. During a review of Resident 1's NPN, dated 4/23/2026, documented by the DON at 5:52 AM, the NPN indicated that the DON received a call from FM 2 that Resident 1 contacted FM 2 but declined to disclose exactly location. During a review of Resident 1's NPN, dated 4/23/2026 documented by RN 1 at 5:54 AM, the NPN indicated RN 1 received a call from the DON that the DON had found Resident 1 at a bus stop. The NPN indicated the DON called paramedics and notified the physician with order to (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer resident to GACH for further treatment and evaluation. During a review of Resident 1's Nurses Progress Note (NPN), dated 4/23/2026 documented by the DON at 5:54 AM, the NPN indicated the DON searched open stores and bus stops, and found the resident sitting on a bench waiting for the bus. The DON assessed Resident 1 and found the resident with no distress, alert, and oriented. The DON also notified FM 2 of the resident status. During an interview on 4/24/2026 at 10:30 AM with Resident 1, Case Manager (CM) 1 for translation, and FM 1, Resident 1 stated around 2 AM, after sitting in the wheelchair in front of the nurse's station, Resident 1 noticed that there were no staff at the station, so the resident stood up and walked to the facility's front entrance. Resident 1 then saw a woman whom he could not identify if she was a staff member and followed her. Resident 1 stated, he followed that woman to the front entrance door and saw that the door was propped open with no staff presented, so he just walked out of the facility. Resident 1 stated he kept walking, crossing a few streets until he found a bus stop and slept there while waiting for a bus. Resident 1 stated he slept at the bus stop for a few hours, around 5-6 AM when he woke up. Resident 1 stated, he saw the police and ambulance came to pick him up. During an observation on 4/24/2026 at 10:45 AM outside Resident 1's room with Resident 1 and CM 1, Resident 1 was sitting in a wheelchair. Resident 1 was able to stand up and walk along the hallway without assistance. During an interview on 4/24/2026 at 12:30 PM with Registered Nurse (RN) 1, RN 1 stated, she was the 11 PM-7 AM shift RN on 4/22/2026. RN 1 stated, she saw Resident 1 at the nurse's station at 2:20 AM on 4/23/2026 but around 2:30 AM, the resident was not there anymore. RN 1 stated, Resident 1 had a habit of waking up at night, sitting in his wheelchair in front of the nurse's station, observing or talking to the staff, then going back to his room to rest. RN 1 stated, Resident 1 liked to walk around the facility. RN 1 stated, the admitting RN was responsible for assessing the residents for elopement risk upon admission to identify the risk. RN 1 stated, all doors are locked at nighttime except for the front entrance door. RN 1 stated, the entrance door will only alarm if the door is kept open for a certain amount of time. RN 1 stated, if a resident left the facility from the front door and closed the door, the alarm would not sound so they would not know right away if a resident left. During a concurrent observation and interview on 4/24/2026 at 1 PM with the Maintenance Supervisor (MS), the MS held the front entrance door open for one minute before the alarm started to sound. The MS stated the door is programed to only alarm after the door is kept open for at least one minute, throughout day and night. During a concurrent interview and record review on 4/24/2026 at 1:14 PM with the Assistant Director of Nurses (ADON), Resident 1's electronic medical record from 4/1/1026 to 4/24/2026 were reviewed. The ADON confirmed that Resident 1 was admitted to the facility on [DATE], and the admitting RN should have completed an elopement risk assessment, which is called Leave of Absence without Notice (LAWN) upon admission for Resident 1 in accordance with the facility's policy. During an interview on 4/24/2026 at 1:18 PM with the DON, the DON stated, if a resident eloped without staff supervision or awareness, the resident would be at risk for falls, injury, being struck by motor vehicles, and missed medications. During an interview on 4/24/2026 at 2:05 PM with the DON, the DON stated that the admitting RN was supposed to complete Resident 1's LAWN upon admission to identify any elopement risks and implement appropriate interventions based on the findings. During a review of the facility's policies and procedures (P&P) titled, Leave of Absence without Notice (LAWN), dated 1/16/2026, indicated: Residents will be evaluated by the interdisciplinary team members (IDT) for possible leave of absence without notice/authorization upon admission, quarterly and when there is a significant change in condition. The IDT is recommended to use the Leave of Absence without Notice flow chart as a guide to consider resident specific factors to determine if resident is at risk for elopement. The P&P indicated a resident deemed at risk for Leave of Absence without Notice by IDT are to consider: a) Initiate/Update plan of care; b) Consider application of a wander guard in collaboration with the physician and responsible party; c) In the absence of a wander guard system the IDT to collaborate and identify measures necessary to avoid leaving the facility without notice/authorization. During a review of the facility's P&P titled, Emergency Procedure - Missing Resident, dated August 2018, (continued on next page)

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