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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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(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. Based on interview and record review, the facility failed to ensure that residents receive adequate supervision and assistance to prevent avoidable accidents when the facility receptionist (unlicensed staff) assisted one of two sampled residents (Resident^6) during a fall on 6/25/2026 at 8:30 PM. Receptionist (REC), an unlicensed staff, assisted Resident 6, who required partial/moderate assistance, off the floor and onto the couch without waiting for a licensed nurse to assess and transfer the resident, in accordance with the facility's policy and procedure (P&P) for Fall Management and the REC's job description. This failure had the potential to result in further injury or avoidable accidents following the fall. On 6/27/2026, Resident 6 complained of severe pain and swelling to the right foot. On the same day, Resident 6 was transferred to a General Acute Care Hospital (GACH) due to severe pain and was diagnosed with fractures of the 4th and 5th metatarsal necks (a break in the neck of two of the five long bones in the forefoot, located just behind the toe joints). Findings: During a review of the REC's Job Description titled Receptionist dated 3/10/2026 indicated the primary purpose of the position was to perform clerical support in an efficient manner in accordance with procedures and as directed by the supervisor. The Job Description did not indicate any duties or responsibilities for direct resident care. A review of the facility's policy and procedure (P&P) titled Fall Management dated 5/26/2021indicated patients will be assessed for falls risk as part of the nursing assessment process. The P&P indicated those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. The P&P indicated that when a patient (resident) falls, staff should Observe/check for injury, which was not implemented immediately when REC witnessed Resident 6 fell on 6/25/2026, prior to moving the resident and lifting Resident 6 off the floor unassisted. During a review of Resident 6's admission Record (AR), the AR indicated a readmission to the facility on 8/5/2025 with diagnoses of unspecified fracture of upper end of right tibia, muscle weakness, and abnormalities of gait and mobility. During a review of Resident 6's History and Physical (H&P) dated 9/18/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Fall risk care plan initiated on 1/28/2026 with target date 7/6/2026, the care plan indicated Resident 6 was at risk for falls related to resident transferring himself unassisted from bed to wheelchair. The care plan indicated Resident 6 will maintain safety awareness during unassisted transfers and will transfer safely without fall. During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/21/2026, the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 6 required partial/moderate assistance for chair/bed-to-chair transfer and sit to stand. During a review of Resident 6's physician orders dated 6/25/2026, the order indicated a physician order to apply ice to the right foot. During a review of Resident 6's Progress notes dated 6/25/2026 timed at 8:30 PM, the Note indicated, Licensed Vocational Nurse (LVN) 7 left the building for his lunch break at 8:05 PM and observed Resident 6 in the lobby, sitting in his wheelchair and talking to peers (Residents 7 and 8. The Note indicated when LVN 7 returned from lunch at 8:35 PM, the Receptionist (REC) notified him of Resident 6's fall while trying to transfer from his wheelchair to the couch in the lobby at 8:30 PM. The Note indicated pain assessment was performed, and Resident (continued on next page)

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	6 had no complaints of pain, discomfort, or distress during that time. The Note indicated with the help of three staff members, Resident 6 was successfully transferred to his wheelchair and back to his room in his bed. The Note indicated no skin alterations, tears, redness, or any injuries observed from full skin assessment. The Note indicated Resident 6 was able to move bilateral upper and lower extremities without complications. During further review of Resident 6's Progress Note, the Note indicated an addendum to progress note dated 6/25/2026 timed at 8:30 PM a clarification that Resident 6 was noted on left side-lying on the floor between wheelchair and couch. The Progress Note indicated according to the REC and Resident 6's interview, Resident 6 was assisted by [REC] staff from floor to couch. The Progress Note indicated the writer noted Resident 6 sitting upright in the couch and denied hitting his head during the fall and no noted changes in level of consciousness (LOC). The Progress Note indicated Resident 6 performed range of motion (ROM) without complain of pain, had no apparent injuries to visible skin and declined to go back to his room for further skin assessment. During a review of Resident 6's Progress notes dated 6/25/2026 timed at 11:25 PM, the Note indicated Resident 6 was assessed and complained of foot pain. The Note indicated pain medication and ice therapy was offered, but Resident 6 declined. The Note indicated non-pharmacological interventions were implemented, including assisting the resident into bed and positioning him comfortably to help alleviate pain, as well as elevating the affected foot on a pillow for support. The Note indicated Resident 6 was encouraged to rest and limit weight-bearing on the affected foot as tolerated. The Note indicated Resident 6 was educated on available pain management options and instructed to notify nursing staff if pain worsened or if he decided he would like pain medication. The Note indicated Resident 6 remained stable with no signs of acute distress. The note indicated the Physician was notified 6/25/2026 at 8:45 PM. During a review of Resident 6's physician orders dated 6/26/2026, the order indicated a STAT (immediately) X-ray (a type of medical imaging that uses radiation to take pictures of the inside of the body) of the right foot. During a review of Resident 6's Radiology Results Report dated 6/26/2026, the report indicated the resident had an x-ray procedure for the right foot for 3+ and complete views. The report indicated acute to subacute 3rd, 4th, and 5th metatarsal neck fractures. During a review of Resident 6's Progress notes dated 6/27/2026 timed at 2:20 AM, the Note indicated that Resident 6's right foot appeared swollen and complained of 10/10 (severe) pain. The Note indicated the physician ordered to transfer Resident 6 to the GACH Emergency Department (ED). During a review of Resident 6's physician orders dated 6/27/2026 timed at 7:41 AM the telephone order indicated for Resident 6 to transfer to the GACH ED. During a review of Resident 6's General Acute Care Hospital's (GACH) Radiology Results dated 6/27/2026, the report indicated the x-ray result for the right foot that showed acute to subacute fracture along the head of the 5th metatarsal bone with 2-millimeter (mm, unit of measure) displacement. During a review of Resident 6's physician order dated 6/27/2026, the order indicated a physician order to wear a CAM Boot and for non-weight bearing (NWB) to the right foot. During a review of Resident 6's physician order dated 6/27/2026, the order indicated a physician order for pain management consultation for pain management. During a review of Resident 6's Interdisciplinary Care Conference Note written on 6/27/2026, the Note indicated that on 6/25/2026 at 8:30 PM, Resident 6 had a witnessed fall in the facility lobby. The note indicated the facility's Receptionist (REC) observed Resident 6 transfer himself from the wheelchair to the couch located at the facility lobby and slipped to the ground. The Note indicated during Resident 6's interview with the Director of Nursing (DON) and Administrator (ADM), Resident 6 did not feel any pain at the time of the fall because his foot was numb. The Note indicated Resident 6 reported transferring self from wheelchair back to bed and was not in pain until trying to sleep for the night on 6/25/2026. During the same review of Resident 6's Interdisciplinary Care Conference Note dated 6/27/2026, the Note further indicated staff reported Resident 6 had pain but declined Norco (brand-name prescription medication containing a combination of hydrocodone [an opioid pain reliever] and acetaminophen [Tylenol, widely used to treat minor aches, pains, and fever]) to Resident 6. The Note indicated Resident 6 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred to the General Acute Care Hospital (GACH) on 6/27/2026 and returned the same day with Controlled Ankle Motion (CAM) boot (fracture boot, an orthopedic brace used to immobilize the foot and ankle, support healing, and reduce weight-bearing stress) in place to the resident's right foot. The Note indicated imaging was done in the GACH that showed acute to subacute fracture of 4th and 5th metatarsal neck whereas facility imaging showed 3rd, 4th, and 5th metatarsal neck fractures. The Note indicated recommendations that included staff education on not moving the resident prior to a Registered Nurse (RN) assessment and Resident 6 was to await staff assistance prior to initiating any transfer. During a review of Resident 6's Progress Notes dated 6/27/2026 timed at 4:43 AM, the Note indicated Resident 6 was transferred to the GACH. During a review of Resident 6's Progress Notes dated 6/27/2026 timed at 8:30 AM, the Note indicated Resident 6 returned from the GACH. During an interview on 6/29/2026 at 10:45 AM, the DON stated Resident 6 fell at the facility lobby while trying to transfer from his wheelchair to the couch and slipped. The DON stated the fall was witnessed by the REC and two other residents (Resident 7 and 8). The DON stated Resident 6 had sustained fractures to the right foot: 3rd, 4th, 5th metatarsal. The DON stated the REC picked up Resident 6 by herself. The DON stated the REC informed the DON that she panicked because the residents had asked her to take a picture of them at the lobby and then Resident 6 fell so she helped Resident 6 back from the floor to the couch unassisted. The DON stated an in-service was initiated and the staff were fully aware of what happened. The DON stated the REC should not have helped Resident 6 and should have waited for a licensed staff to assist Resident 6 back to couch because Resident 6 could have gotten more injured during an unassisted transfer back to the couch. The DON stated Registered Nurse (RN) 3 and LVN 7 advised the REC not to move any resident without licensed staff assistance. During an interview on 6/29/2026 at 11:48 PM, LVN 7 stated that on 6/25/2026 when Resident 6 fell at the lobby, he was on his lunchbreak, but when he came back, he observed Resident 6 sitting upright on the lobby couch and did not observe any injuries or bleeding. LVN 7 stated he and RN 3 asked Resident 6 if he wanted to go back to his room to do a full body assessment and Resident 6 declined. LVN 7 stated pain medication was offered to Resident 6 on 6/25/2026 and the resident told him he was not in any pain. During a telephone interview on 6/29/2026 at 12:15 PM, RN 3 stated on 6/25/2026 during the 3 PM to 11 PM shift, the REC came to the Nursing Station and informed him Resident 6 fell. RN 3 stated REC told him she panicked when she saw Resident 6 fall and instantly went to the resident and tried to bring him to the couch. RN 3 stated by the time REC went to the Nursing Station, Resident 6 was on the couch. During a telephone interview on 6/29/2026 at 12:37 PM, the REC stated she observed Resident 6 transfer from the wheelchair to get on the couch. REC stated Resident 6 fell to the floor, and she got up and said to Resident 6, here let me give you a hand. The REC stated she stood in front of Resident 6 and put her hands out in front of her to pull Resident 6 up, not realizing his legs are weak, I tried to lift him and he was too heavy for me to lift. The REC stated she told Resident 6, you are too heavy, let me go behind you. The REC stated she stood behind Resident 6's right shoulder put both my arms under Resident 6's armpits and tried to lift him up with all my might and put him on the couch and immediately after, I was concerned about my lower back. The REC stated after she assisted Resident 6 on to the couch, she told the RNS on duty and was informed she should have called someone for help, everything happened so fast. The REC stated that RN 3 and LVN 7 assessed Resident 6 and explained that, upon being hired, they were instructed not to pick up residents when they fall. The REC added that she should have followed this instruction. The REC stated Resident 6 did not complain of any pain during the time he was at the facility lobby with his peers (Residents 7 and 8).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the timely availability, ordering, and administration of a prescribed medication (Pregabalin 50 mg, three times daily) for one of three sampled residents (Resident 1). The facility failed to obtain required physician signatures, follow pharmacy procedures, coordinate with appropriate prescribers, communicate medicationˆavailability issues among licensed nursing staff to administer Pregabalin as ordered. The facility's failures caused staff to fail to administer 20 scheduled doses of the controlled medication Pregabalin to Resident 1, leaving the resident with uncontrolled neuropathic pain for more than seven days and negatively affecting their quality of life. Findings: During a review of Resident 1's General Acute Care Hospital (GACH) Transfer/Discharge Medication Review and Order Sheet dated 6/2/2026, the order indicated to continue Pregabalin for diabetic neuropathy (nerve damage caused by long-term high blood sugar and fat levels)] and to manage certain types of seizures) 50 mg, one capsule orally three times a day. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included sepsis (the body's extreme, life-threatening response to an infection), muscle weakness, and sciatica (pain that radiates from the lower back, through the buttock, and down one leg). During a review of Resident 1's Progress notes dated 6/2/2026 timed 8:06 PM indicated Resident 1 was admitted to the facility and admission orders were verified with the MD (Physician 1). The note indicated all orders noted and carried out. During a review of Resident 1's History and Physical Assessment (H&P) dated 6/3/2026 indicated resident had the capacity to understand and make decisions. During a review of Resident 1's Physician Order dated 6/2/2026, a telephone order indicated to give Pregabalin Oral Capsule 50 mg, 1 capsule by mouth three times a day for neuropathic pain starting on 6/3/2026. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screen tool) dated 6/8/2026 indicated Resident 1's cognition was intact. The MDS indicated Resident 1 required partial/moderate assistance for activities of daily living. During a subsequent review of Resident 1's Progress notes dated 6/3/2026 timed 8:12 AM, the note indicated awaiting delivery of Pregabalin Oral Capsule 50 mg give 1 capsule by mouth three times a day for neuropathic pain. During a review of Resident 1's Progress notes dated 6/3/2026 timed 1:20 PM, the note indicated the Pregabalin was not available, and the staff would follow up with pharmacy. During a review of Resident 1's Progress notes dated 6/3/2026 timed 5:49 PM, the note indicated an entry wait for pharmacy delivery. During a review of Resident 1's Progress notes dated 6/4/2026 timed 9:54 AM, the note indicated the Pregabalin order was pending the physician's signature. The note further indicated that according to the facility's pharmacy, to hold the medication until it arrives. During a review of Resident 1's Progress notes dated 6/4/2026 timed 1:02 PM, the note indicated to hold the Pregabalin until the MD signs the order. During a review of Resident 1's Progress notes dated 6/5/2026 timed 10:37 AM, the note indicated the Pregabalin was not available and the pharmacy was called. The note indicated per pharmacy, the licensed nurses could not pull from the facility's Cubex system (Cubex Medication System, an automated inventory management system and smart dispensing cabinet used in medical practices by tracking, securing, and recording high-value supplies and medications), because the physician has not signed the prescription and medication was not ordered as needed [PRN]. The note indicated the physician (Physician 1) and Resident 1 were made aware. During a review of Resident 1's Progress notes dated 6/5/2026 timed 2:02 PM, the note indicated the Pregabalin was not available and the MD was aware. During a review of Resident 1's Medication Administration Record (MAR) from 6/3/2026 to 6/8/2026 scheduled at 9 AM, 1 PM, and 5 PM -the MAR indicated the Pregabalin was not administered to Resident 1 due to medication not delivered by Pharmacy. On 6/9/2026 at 9 AM and 1 PM - the MAR indicated the Pregabalin was not administered to Resident 1 due to medication not delivered by Pharmacy. During a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 1's MAR, dated 6/5/2026 at 1:18 PM, the MAR indicated Resident 1 received one time of tramadol 25 MG for 9/10 (severe) pain level by LVN 1. During a review of Resident 1's MAR for 6/9/2026 timed at 5 PM - the MAR indicated the Pregabalin was documented administered by LVN 2 but during a later interview, the medication was not actually given to the resident. During a review of Resident 1's Progress Notes dated 6/10/2026 timed at 9:13 AM, the order indicated medication on hold, pending Physician 1's signature and that Physician 1 is aware and per Physician 1, to put the medication on hold. During a review of Resident 1's Physician Order dated 6/10/2026 timed at 9:44 AM, a telephone order indicated Physician 1 ordered to hold Pregabalin 50 mg pending the physician's signature. Further review of the resident's records indicated the Pregabalin was not administered due to the medication being on hold. During a review of Resident 1's Physician Order dated 6/10/2026 timed at 11:41 AM, a telephone order indicated Physician 1 ordered to resume Pregabalin 50 mg. During a review of Resident 1's Progress notes dated 6/10/2026 timed at 1:26 PM by LVN 1, the Note indicated the prescription was signed and Pregabalin was pulled from the facility's Cubex system. The medication was still pending pharmacy delivery. During a review of Resident 1's MAR for 6/10/2026 at around 1 PM - the MAR indicated the Pregabalin was administered by LVN 1 from the Cubex. During a review of the facility's Cubex Medication System Transaction Report, dated 6/10/2026 timed at 1:28 PM, the report indicated two capsules of Pregabalin 25 mg (50 mg) were removed from the Cubex for Resident 1 by RN 1 (and administered by LVN 1 in the MAR). During a review of Resident 1's [DATE]/10/2026 at 5 PM- the MAR indicated the Pregabalin was documented administered by LVN 2 but during a later interview, the medication was not actually given to the resident. During a review of the facility's Pharmacy Delivery Receipt dated 6/10/2026, the receipt indicated Resident 1's Pregabalin 50 mg capsule, a total of 30 doses was delivered to the facility on 6/10/2026 at 5:50 PM. During a review of the Pharmacy Copy for Resident 1's Physician's Order, dated 6/10/2026, signed and ordered by Physician 3 (Resident 1's pain specialist), the signed order indicated Physician 3 ordered Pregabalin Oral Capsule 50 mg one capsule by mouth three times a day for neuropathic pain. The Pharmacy Copy indicated the pharmacy received this Physician's Order on 6/10/2026 timed 12:08 PM. During a review of Resident 1's care plan for Missed dose(s) of Pregabalin 50 mg developed on 6/7/2026, the care plan indicated the resident would remain free from pain or discomfort while awaiting medication availability and timely resumption of therapy. During a review of Resident 1's records from 6/2/26 to 6/11/26, the records did not indicate a follow up to obtain the required physician signature to prevent a delay in the delivery of the Pregabalin medication to be administered to the resident since 6/3/2026. During the continued MAR review from 6/3/2026 to 6/15/2026, the Pregabalin was signed as administered to Resident 1 by the licensed nurses 16 times and Pregabalin was not administered 20 times. During a review of Resident 1's printed Controlled Drug Record for Pregabalin 50 mg capsules, with start date on 6/11/2026, the record showed the following administration details: -On 6/11/2026 at 8:11 AM, one dose administered leaving a remaining quantity of 29. -On 6/11/2026 at 12:38 PM, one dose administered, leaving 28. -On 6/11/2026 at 5:57 PM, one dose administered, leaving 27. -On 6/12/2026 at 8:11 AM, one dose administered leaving 26. -On 6/12/2026 at 12:46 PM, one dose administered leaving 25. -On 6/12/2026 at 5:07 PM, one dose administered leaving 24. -On 6/13/2026 at 8:28 AM, one dose administered leaving 23. -On 6/13/2026 at 12:54 PM, one dose administered, leaving 22. -On 6/13/2026 at 4:28 PM, one dose administered, leaving 21. -On 6/14/2026 at 9:03 AM, one dose administered, leaving 20. -On 6/14/2026 at 1:48 PM, one dose administered, leaving 19. -On 6/14/2026 at 5:40 PM, one dose administered, leaving 18. -On 6/15/2026 at 8:40 AM, one dose administered, leaving 17. A total of 13 doses were recorded administered to Resident 1. During a review of Resident's Progress Notes (PN), dated 6/15/2026 timed 10 AM, the notes indicated Resident 1 was discharged to home. During a telephone interview on 6/22/2026 at 12:01 PM with Family Member (FM) 1, FM 1 stated that Resident 1 was admitted to the facility on [DATE] and had been prescribed Pregabalin three times daily for neuropathic pain. FM 1 stated that Resident 1 did not receive the Pregabalin medication for more than a week. FM 1 reported (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	informing multiple nurses at the facility on several occasions that Resident 1 needed the pain medication, but the nurses repeatedly responded that the pharmacy was waiting for the physician's signature and authorization before delivering the Pregabalin. FM 1 stated that during the time [Resident 1] did not receive the Pregabalin, Resident 1 experienced and verbalized uncontrolled pain in her lower legs for over a week. During a concurrent interview and record review on 6/22/2026 at 12:40 PM with Licensed Vocational Nurse (LVN) 1, Resident 1's Progress Notes, dated 6/5/2026 timed 10:26 AM, was reviewed. LVN 1 stated she called and informed Resident 1's primary physician (Physician 1) on 6/5/2025 and notified Physician 1 that Resident 1's Pregabalin was not delivered since it was ordered on admission to start on 6/3/2026 because the pharmacy required a signed prescription from the physician before the medication would be delivered to the facility. LVN 1 further stated Physician 1 informed her that the facility can contact the facility's Medical Director (Physician 2) who could sign the prescription on his behalf. LVN 1 stated she did not contact the facility's Medical Director (Physician 2) regarding Resident 1's prescription for Pregabalin. LVN 1 stated she waited a few days (7 days) until the facility's pain management specialist (Physician 3) came to the facility, at which time she presented Resident 1's prescription of Pregabalin for Physician 3's authorization and signature. During a concurrent interview and record review on 6/22/2026 at 12:45 PM with LVN 1, Resident 1's Progress Notes, dated from 6/2/2026 to 6/10/2026, were reviewed. LVN 1 stated she could not find documentation indicating other licensed nurses had contacted the physicians (Physicians 1, 2, or 3) regarding the signature required by Pharmacy to deliver the Pregabalin at the facility. During another interview on 6/22/2026 at 12:48 PM with LVN 1, LVN 1 further stated Resident 1's Pregabalin was ordered to start on 6/3/2026 and when the nurses found out the medication was not available due to pending signature from the admitting physician (Physician 1), the nurses should have contacted Physician 1 right away on 6/3/2026 to obtain the signature. LVN 1 stated if the admitting physician (Physician 1) was not available and could not sign the prescription, the nurse should have called Physician 2, the Medical Director or Physician 3, the facility's pain specialist, to sign the prescription as soon as possible to prevent the delay of administering the Pregabalin to Resident 1. LVN 1 stated there was no licensed nurses that called and followed up with any physicians for the signature on 6/3/2026 and 6/4/2026. LVN 1 stated there were no other licensed nurses that followed up with any physician to obtain the signature on 6/6/2026, 6/7/2026, 6/8/2026, and 6/9/2026. During an interview on 6/22/2026 at 2:43 PM with the Assistant Director of Nursing (ADON), the ADON stated that Pregabalin is a controlled medication that requires a physician's signature before the pharmacy can release it to the facility. The ADON explained that when licensed nurses discovered Pregabalin was unavailable due to a pending physician signature, they should have contacted Physician 1 immediately. The ADON further stated that if the resident's admitting physician was not available or unable to sign the prescription, licensed nurses should contact the facility's medical director or pain management specialist for the required signature. The ADON emphasized that nurses should not wait for the physician to arrive at the facility to sign the prescription. The ADON further stated that because licensed nurses did not contact a physician in a timely manner to obtain the signature for Resident 1's Pregabalin, Resident 1 did not receive her routine painˆmanagement medication for seven days, resulting in discomfort and negatively affecting her quality of life. During a concurrent interview and record review on 6/23/2026 at 2:45 PM with ADON, the facility's policy and procedures (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated 1/2026, was reviewed. The ADON stated the controlled medications prescribed for a specific resident are delivered to the facility only if a valid written or electronic prescription had been received by the pharmacy prior to dispensing. The ADON stated it was important for nurses to be aware of the procedure and notified the physician for signature to prevent future delay of care for the residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with professional standards of practice for one of three sampled residents (Resident 1). Licensed Vocational Nurse (LVN) 2 documented in Resident 1's Medication Administration Record (MAR) that Pregabalin (a controlled medication [a medication carries the risk of abuse, misuse, and physical or psychological dependence] used to treat nerve pain) 50 mg was administered to the resident on 6/9/2026 at 5 PM and 6/10/2026 at 5 PM. However, the medication was not available in the facility at those times or delivered by the pharmacy and was not administered to the resident. On 6/10/2026 at 5:50 PM, the medication was delivered by the pharmacy, approximately 24 hours after LVN 2 documented giving the medication to Resident 1. This deficient practice failed to ensure accurate medication documentation and had the potential to cause medicationˆrelated errors, compromise the resident's clinical care, and mislead healthcare providers relying on the MAR for treatment decisions. Findings: During a review of Resident 1's General Acute Care Hospital (GACH) Transfer/Discharge Medication Review and Order Sheet dated 6/2/2026, the order indicated to continue Pregabalin for diabetic neuropathy (nerve damage caused by long-term high blood sugar and fat levels)] and to manage certain types of seizures) 50 mg, one capsule orally three times a day. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included sepsis (the body's extreme, life-threatening response to an infection), muscle weakness, and sciatica (pain that radiates from the lower back, through the buttock, and down one leg). During a review of Resident 1's Progress notes dated 6/2/2026 timed 8:06 PM indicated Resident 1 was admitted to the facility and admission orders were verified with Physician 1. The note indicated all orders noted and carried out. During a review of Resident 1's Physician Order dated 6/2/2026, a telephone order indicated to give Pregabalin Oral Capsule 50 mg, 1 capsule by mouth three times a day for neuropathic pain starting on 6/3/2026. During a review of Resident 1's History and Physical Assessment (H&P) dated 6/3/2026 indicated resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screen tool) dated 6/8/2026, the MDS indicated Resident 1's cognition was intact. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for shower/bathing self, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, and chair/bed-to-chair transfer. During a review of Resident 1's Medication Administration Record (MAR) for June 2026, the MAR indicated the following information for Pregabalin 50 mg capsule on the following dates: On 6/3/2026, 6/4/2026, 6/5/2026, 6/6/2026, 6/7/2026, 6/8/2026 scheduled at 9 AM, 1 PM, and 5 PM -the MAR indicated the Pregabalin was not administered to Resident 1. On 6/9/2026 at 9 AM and 1 PM - the MAR indicated the Pregabalin was not administered. On 6/9/2026 at 5 PM - the MAR indicated the Pregabalin was documented as administered by LVN 2. On 6/10/2026 at 9 AM - the MAR indicated the Pregabalin was on Hold by LVN 1. On 6/10/2026 at 1 PM - the MAR indicated the Pregabalin was administered as indicated by LVN 1 in the MAR, taken from the facility's Cubex. On 6/10/2026 at 5 PM- the MAR indicated the Pregabalin was documented as administered by LVN 2. During a subsequent review of Resident 1's Progress notes from 6/3/2026 to 6/5/2026, the Notes indicated the Pregabalin Oral Capsule 50 mg was not available at the facility due to a pending authorization signature required from the ordering physician and the pharmacy instructed the facility to hold administration until delivered. During a review of Resident 1's Progress notes dated 6/5/2026 timed 10:37 AM, the note indicated the Pregabalin was not available and the pharmacy was called. The note indicated per pharmacy, the licensed nurses could not pull from the facility's Cubex system (Cubex Medication System, an automated inventory management system and smart dispensing cabinet used (continued on next page)

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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in medical practices by tracking, securing, and recording high-value supplies and medications), because the physician has not signed the prescription and medication was not ordered as needed [PRN]. The note indicated the physician (Physician 1) and Resident 1 were made aware. During a review of Resident 1's Progress notes dated 6/5/2026 timed 2:02 PM, the Note indicated the Pregabalin was not available and the MD was aware. During a review of the facility's Cubex Medication System Transaction Report, there was no Cubex record showing Pregabalin capsules were removed on 6/9/2026 at 5 PM by LVN 2 or any other licensed nurses. During a review of Resident 1's Progress notes dated 6/10/2026 timed 9:13 AM, the Note indicated medication on hold, pending the physician's signature, the note indicated the physician was aware and to put on hold. During a review of Resident 1's Physician Order dated 6/10/2026 timed at 9:44 AM, a telephone order indicated Physician 1 ordered to hold Pregabalin 50 mg pending the physician's signature. Further review of the resident's records indicated the Pregabalin was not administered due to the medication being on hold. During a review of Resident 1's Physician Order dated 6/10/2026 timed at 11:41 AM, a telephone order indicated Physician 1 ordered to resume Pregabalin 50 mg. During a review of Resident 1's Progress notes dated 6/10/2026 timed at 1:26 PM by LVN 1, the Note indicated the prescription was signed and Pregabalin was pulled from the facility's Cubex system. The medication was still pending pharmacy delivery. During a review of the facility's Cubex Medication System Transaction Report, there was no Cubex record showing Pregabalin capsules were removed on 6/10/2026 at 5 PM by LVN 2 or any other licensed nurses, which contradicts LVN 1's MAR documentation indicating the medication was administered to Resident 1 at that time. During a review of the facility's Pharmacy Delivery Receipt dated 6/10/2026, the receipt indicated Resident 1's Pregabalin 50 mg capsule, a total of 30 doses was delivered to the facility on 6/10/2026 at 5:50 PM. During a telephone interview on 6/22/2026 at 12:01 PM with Family Member (FM) 1, FM 1 stated that Resident 1 was admitted to the facility on [DATE] and had been prescribed Pregabalin three times daily. FM 1 stated that Resident 1 did not receive the medication for more than a week. FM 1 reported informing multiple nurses on several occasions that Resident 1 needed the pain medication, but the nurses repeatedly responded that the pharmacy was waiting for the physician's signature and authorization before delivering it. FM 1 stated that during this time without the medication, Resident 1 experienced uncontrolled pain in her lower legs for over a week. During a concurrent interview and record review on 6/23/2026 at 3 PM with LVN 2, LVN 2 stated that she documented Resident 1 as having received Pregabalin 50 mg on the MAR for 6/9/2026 at 5 PM and 6/10/2026 at 5 PM; however, the medication was not delivered to the facility until 6/10/2026 at 5:50 PM. LVN 2 stated she did not borrow Pregabalin from other residents and did not obtain it from the facility's Cubex system. LVN 2 confirmed that she did not administer Pregabalin 50 mg to Resident 1 on either 6/9/2026 or 6/10/2026 at 5 PM, but nevertheless documented the doses as administered on the MAR. LVN 2 stated she should have documented that the Pregabalin was not administered to Resident 1 on 6/9/2026 at 5 PM and 6/10/2026 at 5 PM. During a concurrent interview and record review on 6/23/2026 at 3:02 PM with the Assistant Director of Nursing (ADON), Resident 1's Physician Orders dated 6/2/2026, the MAR for June 2026, the facility's Cubex Medication System transaction report dated 6/10/2026, the Pharmacy Delivery Receipt dated 6/10/2026, and Resident 1's Controlled Drug Record for Pregabalin (6/11/2026-6/15/2026) were reviewed. The ADON stated there was no Cubex record showing Pregabalin capsules were removed on 6/9/2026 at 5 PM or 6/10/2026 at 5 PM. The ADON stated LVN 2 did not administer Pregabalin 50 mg to Resident 1 at those times, although the doses were documented as given on the MAR. The ADON stated that LVN 2's documentation did not accurately reflect the care Resident 1 received, and such discrepancies could compromise resident safety and lead to medication errors. The ADON further stated that professional standards require licensed nurses that included LVN 2 to document medications only after administering them. During a review of the facility's Policy and procedures (P&P) titled, Guidelines for Charting and documentation, dated 4/2012, the P&P indicated the purpose of charting and documentation is to provide a complete (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	account of the resident's care, treatment, response to the care, signs symptoms and the progress of the resident's care. The P&P indicated charting to be concise, accurate and complete. During a review of the facility's P&P titled, Administering Medications, dated 4/2019, the P&P indicated The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. During a review of the facility's P&P titled, Code of Conduct, dated 11/16/2020, the P&P indicated the facility was committed to following all applicable policies, laws and licensing/accreditation requirement relating to quality of care and patient safety, and uphold the professional standard of care, report patient safety concerns, and engage in quality improvement.