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	03/01/2025

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. 47467 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 392), was provided privacy and treated with dignity when being changed on 2/25/2025 at 11:13 AM. This failure resulted in the violation of residents right for privacy and dignity that resulted in the resident feeling upset and a potential to result in Resident 392's emotional distress. Findings: During a review of Resident 392's Admission Record (AR), the AR indicated the facility admitted Resident 392 on 2/19/2025 with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), muscle weakness, and lack of coordination. During a review of Resident 392's History and Physical Examination, dated 2/19/2025, indicated Resident 392 did not have the capacity to understand and make decisions. During an observation on 2/25/2025 at 11:13 AM in Resident 392's room, Certified Nurse Assistant (CNA) 6 was assisting Resident 392 change clothing and exposed the resident from the waist up and the privacy curtain was not completely closed and was halfway pulled open. When Resident 392 noticed the surveyor walked by, Resident 392 looked upset and pulled her gown up to cover herself. During an interview on 2/25/2025 at 11:15 AM with CNA 6, CNA 6 stated, she was assisting Resident 392 to get changed. CNA 6 stated, Resident 392 was exposed to any visitors who came in the room because she forgot to pull the privacy curtain fully. During an interview on 2/25/2025 at 12:15 PM with Resident 392, Resident 392 was confused and not able to answer any question. During an interview on 2/28/2025 at 4:20 PM with the Acting Director of Nursing (ADON), the ADON stated, CNA 6 must pull the curtain fully closed to provide privacy to Resident 392 first before informing Resident 392 that she would start assisting the resident with getting changed. The ADON stated, even if the resident was confused, and forgetful, the resident could still be upset, and their dignity could get hurt. (continued on next page)

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 the facility's Policy and Procedure (P&P) titled, Dignity, revised 2021, indicated staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to accommodate the needs of the residents by failing to ensure the resident ' s call light (a device used by residents to signal his or her needs for assistance) is accessible to the residents at all times, in accordance with their resident assessments on functional abilities and the facility ' s policy and procedure (P&P) on Answering the Call Light, for three of four sampled residents (Resident 56, 15, and 73). These deficient practices resulted in Residents 56, 15 and 73 not able to use their call light devices to call the facility staff to ask for help or assistance for basic needs of activities of daily living (ADLs). These deficient practices also had the potential for other residents to have delay in care and services, avoidable falls, and accidents. Findings: A review of the facility ' s P&P titled, Answering the Call Light, dated 10/24/2024 indicated the purpose of the policy is to ensure timely responses to the resident ' s requests and need. The policy further indicated to Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 1. During a review of Resident 73 ' s Admission Record (AR), the AR indicated the facility admitted Resident 73 on 8/26/2023, with diagnoses that included diabetes mellitus (a group of diseases that result in too much sugar in the blood) and acquired absence of right leg below knee (loss of right leg below the knee). During a review of Resident 73 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/6/2025, the MDS indicated Resident 73 had intact memory and cognition (ability to think and reason). The MDS assessment under Functional Abilities and Goals indicated Resident 73 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, and personal hygiene, substantial/maximal assistance with chair/bed-to-chair transfer, and dependent with toileting hygiene and shower/bathe self. The MDS indicated Resident 73 required partial/moderate assistance with rolling to left and right (ability to roll from lying on back). During a concurrent observation and interview on 2/25/2025 at 9 AM, Resident 73 was sitting on his bed with the head of bed (HOB) elevated greater than 45 degrees and Resident 73 was looking for his call light device. During the observation, Resident 73 ' s call light cord was clipped onto the bed fitted sheet on the left side of the resident ' s HOB and the call light button was hanging behind the HOB. Resident 73 was unable to see the call light device hanging behind the HOB. Resident 73 stated he needed the call light to get a staff to look at his left foot toenails because it was bothering him, but he could not find his call light. During the observation, Resident 73 ' s left big toenail was thick, long, and brown in color. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent observation and interview on 2/25/2025 at 9:05 AM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 73 ' s call light was hanging behind the bed mattress, and Resident 73 could not reach his call light. CNA 2 stated Resident 73 ' s call light was out of the resident ' s reach. CNA 2 stated if the resident ' s call light was not within reach, the resident could not ask for help when needed. 2. During a review of Resident 15 ' s AR, the AR indicated the facility originally admitted Resident 15 on 11/2/2023 and readmitted on [DATE] with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and muscle weakness. During a review of Resident 15 ' s MDS, dated [DATE], the MDS indicated Resident 15 had moderately impaired memory and cognition. The MDS indicated Resident 15 required partial/moderate assistance with eating, oral hygiene, personal hygiene, and chair/bed-to-chair transfer, and was dependent with toilet hygiene and shower/bathe self. The MDS indicated Resident 15 required substantial/maximum assistance with rolling to left and right (ability to roll from lying on back). During a concurrent observation and interview on 2/25/2025 at 9:46 AM, with Resident 15, Resident 15 was lying on the bed with HOB elevated 45 degrees and her call light cord and button were placed on the top of the nightstand against the wall. During the observation, Resident 15 was unable to see her call light was placed on top of the nightstand and not within the resident ' s reach. Resident 15 stated she could not find her call light and she needed a staff to change her brief (incontinence brief). Resident 15 stated she could not call any staff if her call light is not within her reach. During a subsequent observation and interview on 2/25/2025 at 9:50 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 15 ' s call light was placed on the top of the nightstand and Resident 15 could not reach the call light. LVN 1 stated resident ' s call lights should be within resident ' s reach at all times so the resident could use it for staff assistance when needed. LVN 1 stated she did not know why and for how long the call light button was placed on the top of Resident 15 ' s nightstand. 3. During a review of Resident 56 ' s AR, the AR indicated the facility originally admitted Resident 56 on 7/14/2021 and readmitted on [DATE] with diagnoses that included schizophrenia (a chronic mental disorder characterized by disruptions in thought processes, perceptions, emotions, and social interactions) and hypertension (high blood pressure). During a review of Resident 56 ' s MDS, dated [DATE], the MDS indicated Resident 56 had severely impaired memory and cognition. The MDS indicated Resident 56 required supervision or touching assistance for toileting hygiene, shower/bathe self, personal hygiene, and chair/bed-to-chair transfer. The MDS indicated Resident 56 required supervision/touching assistance when walking. During an observation on 2/25/2025 at 10:23 AM, an unknown facility staff wheeled Resident 56 who was sitting on a wheelchair, back to his room. During the observation, Resident 56 was left sitting on his wheelchair at the bedside, next to the foot of the bed with his call light cord not within the resident ' s reach. Resident 56 ' s call light button was stuck on the bed frame by the HOB and far from resident ' s reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent observation and interview with Resident 56, on 2/25/2025 at 10:25 AM, Resident 56 stated he could not reach his call light while sitting on his wheelchair. Resident 56 stated he needed to call staff to assist him to go back to his bed. Resident 56 was observed bend over from his wheelchair, attempting to reach the call light stuck on the bed frame by the HOB. During an observation and interview on 2/25/2025 at 10:30 AM, with CNA 1, CNA 1 stated Resident 56 could not reach his call light button stuck on the bed frame by the HOB. CNA 1 stated the staff that wheeled Resident 56 back to his room, should have placed Resident 56 ' s call light within reach before leaving the resident in his room. CNA 1 stated placing the resident ' s call light within reach is important so Resident 56 could use the call light to ask for help when needed. During an interview on 2/28/2025 at 7 PM, with the Acting Director of Nursing (ADON), the ADON stated call light should be within residents ' reach at all times to ensure to provide assistance and meet their needs, especially during an emergency situation.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 36943 Based on observation, interview, and record review, the facility failed to inform one of one sample resident (Resident 44), including 11 of 12 residents alert and oriented residents who were present during a group interview, of their rights and responsibilities. This failure had the potential for the residents to feel uninformed and unable to fully exercise their rights while residing in the facility. Findings: During a review of the Resident Council Minutes, dated 8/21/2024, the Resident Council Minutes indicated the Activity Director (AD) reminded the residents about the smoking policy and procedure (P&P). During a review of the Resident Council Minutes, dated 9/18/2024, the Resident Council Minutes indicated the AD discussed the smoking P&P with the residents. During a review of the Resident Council Minutes, dated 10/16/2024, the Resident Council Minutes indicated the AD reviewed the grievance process with the residents. During a review of the Resident Council Minutes, dated 11/21/2024, the Resident Council Minutes did not include informing the residents of their rights. During a review of the Resident Council Minutes, dated 12/18/2024, the Resident Council Minutes indicated the AD reviewed the grievance process with the residents. During a review of the Resident Council Minutes, dated 1/15/2025, the Resident Council Minutes did not include informing the residents of their rights. During a review of the Resident Council Minutes, dated 2/19/2025, the Resident Council Minutes indicated the AD reviewed the smoking P&P with the residents. During a group interview on 2/25/2025 at 2:45 PM in the Activity Room, 12 alert and oriented residents, including Resident 44, were present during the group interview. Eleven of the 12 residents stated that the facility did not provide any information about the residents ' rights. Resident 44 stated the Resident Council became more informed of their rights once the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) started attending the monthly Resident Council Meetings (unspecified date). (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 2/18/2025 at 10:15 AM with the AD, the facility ' s Activity Calendars and Resident Council Minutes, dated 8/21/2024, 9/18/2024, 10/16/2024, 11/21/2024, 12/18/2024, 1/15/2025, and 2/19/2025, were reviewed. The AD stated the Activity Calendar did not include informing the residents about their rights. The AD reviewed the Resident Council Minutes and stated the smoking and grievance policies were reviewed with the residents. The AD stated the Resident Council Minutes did not indicate the residents were informed of other residents ' rights. The AD observed the facility ' s Activity Room and stated the Activity Room did not have any posted information about the residents ' rights. During an interview on 2/28/2025 at 10:41 AM in Resident 44 ' s room, Resident 44 stated the residents would feel empowered (feel more confident) if the residents knew their rights at the facility. During a review of the facility ' s P&P titled, Resident Rights, revised 12/2021, the P&P indicated the Federal and State laws guaranteed certain basic rights to all residents of the facility, including the right to be informed about his or her rights and responsibilities.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 36943 Based on observation, interview, and record review, the facility failed to ensure the most recent State and Federal survey inspection results were posted in a manner that was clear and visible for residents that included 11 of 12 residents who attended a group meeting, and their families. This failure had the potential to prevent the residents and their families from viewing the survey inspection results without having to ask the facility ' s receptionist. Findings: During an observation on 2/25/2025 at 7:46 AM in the front lobby, an empty file holder was mounted to the wall next to the facility ' s bulletin board. The bulletin board had a posted note indicating, Survey results readily accessible please see receptionist. During a group interview on 2/25/2025 at 2:45 PM in the Activity Room, 12 alert and oriented residents were present during the meeting. Eleven of the 12 residents stated the survey inspection results were not posted or readily available for the residents and families to view. During a concurrent observation and interview on 2/26/2025 at 7:04 AM in the front desk with Receptionist 1, Receptionist 1 stated a receptionist was present in the front desk from 6:30 AM to 10 PM and was not present from 10 PM to 6:30 AM. Receptionist 1 was observed retrieving a large binder from behind the front desk. The large binder was labeled as the facility ' s survey results from 1/2024 to 12/2024. Receptionist 1 stated the facility ' s survey results from 1/2025 were not located at the front desk. During an interview on 2/28/2025 at 7:06 PM with the Administrator (ADM), the ADM stated the facility ' s survey inspection results were available with the receptionists at the front desk because the binders were too heavy to place in existing file holder mounted on the wall next to the bulletin board. During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights, revised 12/2021, the P&P indicated the Federal and State laws guaranteed certain basic rights to all residents of the facility, including the right to examine survey results.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to inform, explain and follow up with the residents' representatives (RP) and offer to assist the residents and their RPs with formulating an Advance Directive (AD- legal documents that express a person's wishes regarding their medical care in the event they become unable to make decisions for themselves due to illness, injury, or incapacity) upon admission for three of three sampled residents (Resident 63, 180, and 391). As a result of this deficient practice Resident 63, 180 and Resident 391 was not able to exercise their resident's rights to express their wishes to meet the care and medical treatment decisions. Findings: 1. During a review of Resident 63's Admission Record (AR), the AR indicated Resident 63 was initially admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses that included pneumonia, chronic obstruction pulmonary disease (COPD - a lung disease characterized by long-term poor airflow) with acute exacerbation, and acute pulmonary edema (condition caused by excess fluid in the lungs). During a review of Resident 63's Social Services Assessment & Documentation (SSAD), dated 1/29/2025, indicated there was no AD in place and there was no clinical record that indicated the AD care planning was provided an opportunity to complete AD was offered to Resident 63's representative. During a review of Resident 63's History and Physical Examination (HPE), dated 1/31/2025, indicated Resident 63 did not have the capacity to understand and make decision. During a review of Resident 63's Minimal Data Set (MDS-a federally mandated resident assessment), dated 2/4/2025, indicated Resident 63's cognition (ability to think, remember, and reason with no difficulty) was moderately impaired and needed moderate assistance (helper does less than half the effort) in personal hygiene. During an interview on 2/27/2025 at 10:10 AM with the Social Service Worker (SSW), the SSW stated, he did not contact Resident 63's family member (the resident's RP) to provide AD information and offer to assist them to formulate an AD. 2. During a review of Resident 180's AR, the AR indicated the facility admitted Resident 180 on 1/29/2025 with diagnoses that included pneumonia (a severe an infection of the lungs that may be caused by bacteria, viruses, or fungi), sepsis (a life threatening infection in the blood which could lead to decreased in BP, increased HR, shortness of breath and altered level of consciousness, that can damage the body organs). During a review of Resident 180's SSAD, dated 1/30/2025, indicated Resident 180's Family Member 1 (FAM 1) was the resident's legal RP. The SSAD indicated, there was no AD in place for Resident 180. The SSAD indicated no additional conversation regarding AD care planning was provided and no opportunity to complete AD was offered to Resident 180 or FAM 1. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 180's MDS, dated [DATE], indicated Resident 180's cognition (ability to think, remember, and reason with no difficulty) was intact and needed partial assistance (helper does less than half the effort) in eating and personal hygiene. During an interview on 2/25/2025 at 10:07 AM with Resident 180's FAM 1, FAM 1 stated, the facility had not informed or explained to him about AD and offered to help Resident 180 to formulate an AD. During an interview on 2/27/2025 at 10:10 AM with the SSW, the SSW stated, since Resident 180 was admitted to the facility on [DATE], the SSW stated he did not have a chance to meet with Resident 180's FAM 1 to discuss the AD information and offer Resident 180 and FAM 1 to formulate an AD. The SSW stated, he was not trained to assist with formulating an AD and did not know that he could contact FAM 1 via phone to go over the AD information. The SSW stated, he also waited until he could meet in person with the resident or the resident's RP. 3. During a review of Resident 391's AR, indicated Resident 391 was admitted to the facility on [DATE] with diagnosis that included bilateral primary osteoarthritis (a common joint disease that causes the breakdown of cartilage, the protective tissue that cushions the ends of bones) of knee, hypertension (high blood pressure), and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities. During a review of Resident 391's HPE, dated 2/25/2025, indicated Resident 391 did not have the capacity to understand and make decisions. During a review of SSAD for Resident 391, dated 2/25/2025, indicated there was no AD in place for Resident 391 and there was no clinical record that indicated the AD care planning was provided an opportunity to complete AD was offered to Resident 391's representative. During an interview on 2/27/2025 at 10:15 AM with the SSW, the SSW stated, Resident 391 was newly admitted to the facility on [DATE] and did not have an existed AD on file when she was admitted . The SSW stated, he had not met Resident 391 in person to go over the AD information or offer Resident 391 and her RP to formulate an AD. During an interview on 2/28/2025 at 4:22 PM with the Acting Director of Nursing (ADON), the ADON stated, the AD information should be explained right upon admission and SSW was responsible to offer/assist the resident and the resident's RP to formulate an AD if there was no AD in place. The ADON stated, it was very important to explain and offer the resident and the resident's RP to formulate an AD because the facility needed to know the treatment decision based on resident's wishes. During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated 3/23/2022, indicated upon admission, Admission Staff or designee will inform the resident of their right to execute an Advance Directive Form, if one does not already exist. The Facility will honor resident's Advance Directive and will provide the resident with information related to Advance Directives upon admission. If no Advance Directive exists, the facility provides the resident with an opportunity to complete the Advance Directive Form upon resident request.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation, interview, and record review, the facility failed to notify the physician for two of two sampled residents (Resident 14 and Resident 25) of sediment (accumulation of particles or debris that settle at the bottom of the urine bag) of the indwelling catheter (flexible tube that collects urine) bag between 2/25/25-2/28/25. This failure resulted in the delay of Resident 14 and Resident 25's Change of Condition (CoC), which had the potential to result in the delay in treatment for urinary tract infection (UTI, an infection in any part of the urinary system, the kidneys, bladder, or urethra) and reoccurrence of UTIs. Crossed Reference with F690 Findings: 1. During a review of Resident 14's Admission Record, the facility admitted Resident 14 on 1/19/2022 and readmitted Resident 14 on 8/22/2024 with diagnoses of Chronic Respiratory Failure (long term condition where the lungs cannot get enough oxygen), Neuromuscular Dysfunction of Bladder (damage to the nerves that control the bladder), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness that affected one side of the body) following cerebral infarction (stroke, that occurred when blood flow to the brain was blocked) affecting the right dominant side. During a review of Resident 14's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 10/31/2022, Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 12/13/2024, the MDS indicated Resident 14 rarely made decisions regarding tasks for daily life. The MDS indicated Resident 14 was dependent (helper does all the effort) on staff for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as toileting and was dependent on staff to assist in turning from his back to his left or right side and turning to lie on his back on the bed. The MDS indicated Resident 14 had an indwelling suprapubic catheter (a tube that drains urine from the bladder) and was always incontinent (loss of control) of bowel. The MDS indicated Resident 14 had neurogenic bladder and obstructive uropathy (condition where the urinary tract was blocked). During a review of Resident 14's Order Summary Report (physician order), start date of 8/22/2024, Resident 14's order indicated to monitor for signs and symptoms of new onset of: fever, hematuria (blood in urine), cloudy urine output, foul odor urine, or decrease urine output. This order's instructions included for every day and night shift, to start a Change of Condition (CoC) documentation if any of the following symptoms were noted and to notify the physician, supervisor, and family. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's care plan, date revised on 12/30/2024, Resident 14 requires indwelling suprapubic catheter due to neuromuscular dysfunction of bladder. The care plan goal was for no signs and symptoms of urinary tract infection for 90 days. The care plan's interventions included to monitor for signs and symptoms of infection and report to physician, to monitor urine for sediment, cloudy, odor, blood, and amount, to report to physician promptly if the urine contained any sediments (free floating particles), blood, cloudiness or odorous, or a fever. During a review of Resident 14's MAR, dated February 2025, the MAR indicated Resident 14 did not have any signs or symptoms for a new onset of hematuria, cloudy urine output, foul odor urine, or decrease urine output. During an observation on 2/27/2025 at 8:22AM in Resident 14's room, Resident 14's foley catheter drainage tubing and foley catheter bag had yellow urine with sediment. During a concurrent observation and interview on 2/27/2025 at 10:22AM with Treatment Nurse (TXN) 5 in Resident 14's room, Resident 14's indwelling catheter bag was observed. TXN 5 stated, Resident 14's urine looked yellow with some sediment. During an interview on 2/28/2024 at 10:15AM with RN 3, RN 3 stated, the certified nurse assistants (CNA) document Resident 14's urine amount on paper and the licensed nurses documents the resident's urine appearance and characteristics in progress notes in the Electronic Medical Records (EMR). During a concurrent interview and record review on 2/28/2025 at 10:19AM with Registered Nurse (RN) 3, Resident 14's Physician Orders, Care Plans, MAR, TAR, and Progress notes were reviewed. RN 3 stated, the physician was not aware of Resident 14's urine characteristic because there was no Change of Condition (CoC) documentation. RN 3 stated, the physician was not informed of the presence of sediment in the urine as indicated in the Resident's care plan. During an interview with RN 3 stated, for Resident 14's the physician was not informed for the presence of sediment in the urine had sediment as indicated in the resident' s plan of care. 2. During a review of Resident 25's Admission Records, the facility admitted Resident 25 on 7/10/2010 and readmitted [DATE] with diagnoses that included acute and chronic respiratory failure (long term condition where the lungs cannot get enough oxygen), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness that affected one side of the body) following cerebral infarction (stroke that occurred when blood flow to the brain was blocked) affecting left non-dominant side, obstructive and reflux uropathy (blockage to the urinary tract, which can lead to kidney damage), and hydronephrosis (urine build up in the kidneys). During a review of Resident 25's Order Summary Report (physician order), start date of 7/23/2024, Resident 25's order indicated to monitor for signs and symptoms of new onset of: fever, hematuria, cloudy urine output, foul odor urine, decrease urine output, change in mental status. This order's instructions included for to be monitored every day and night shift. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's care plan, created on 1/19/2024, the care plan indicated Resident 25 required an indwelling foley catheter due to her diagnosis of obstructive uropathy and urinary retention. The care plan's interventions, dated 1/19/2024, indicated to monitor for signs and symptoms of infection and to report to the physician, to monitor urine output for color, consistency, and amount, to monitor for sediment, cloudy odor, blood, and amount, and to report to physician promptly if the urine contains any sediment, blood, cloudiness or odorous, or if resident has a fever. During a review of Resident 25's H&P, dated 1/15/2025, the H&P did not have any documented evidence Resident 25 had the capacity to understand or make decisions. During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25 rarely made decisions regarding tasks of daily life. The MDS indicated Resident 25 was dependent on staff for all ADLs and dependent on staff to assist Resident 25 in turning from her back to her left or right side and to returning to lying on her back on the bed. The MDS indicated Resident 25 had an indwelling catheter and was always incontinent of bowel. The MDS indicated Resident 25 had obstructive uropathy. During a review of Resident 25's MAR, dated February 2025, the MAR indicated Resident 25 did not have any signs or symptoms for a new onset of hematuria, cloudy urine output, foul odor urine, or decrease urine output. During an observation on 2/25/2025 at 11:57AM in Resident 25's room, Resident 25's indwelling catheter drainage tubing and catheter bag had yellow urine with sediment. During another observation on 2/27/2025 at 8:40AM in Resident 25's room, Resident 25's indwelling catheter drainage tubing and catheter bag had yellow urine with sediment. During a concurrent observation and interview on 2/27/2025 at 10:15AM with TXN 5 in Resident 25's room, Resident 25's indwelling catheter bag and tubing was observed. TXN 5 stated, Resident 25's urine looked yellow with some sediment. During an interview on 2/27/2025 at 10:22AM with TXN 5, TXN 5 stated the physician was not notified of Resident 14 or Resident 25's urine appearance because Residents 14 and 25 had orders for the indwelling catheter to be flushed with 50 milters of normal saline. During a concurrent interview and record review on 2/28/2025 at 10:30AM with Registered Nurse (RN) 3, Resident 25's Physician Orders, Care Plans, Medication Administration Record (MAR), Treatment Administration Record (TAR), and Progress notes were reviewed. RN 3 stated, the physician was not aware of Resident 25's urine characteristic because there was no CoC documentation. RN 3 stated, for the residents that were non-verbal it was important to identify the monitor the resident's vital signs and signs and symptoms. RN 3 stated, it was important to notify the physician of any change of condition such as sediment in the urine because it could be there was something abnormal happening within the resident's body system such as an infection. During a review of the facility's policies and procedures, titled Change in Condition: Notification of, dated 8/25/2021, the P&P indicated the facility must immediately inform the resident's physician where there is a significant change in the Resident's physical, mental, or psychosocial status.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to provide privacy during incontinent (no control bladder and bowel) care for one of one sampled resident (Resident 19). Certified Nursing Assistant (CNA) 18 did not close the privacy curtain while performing perineal care (cleaning the private areas of the body, including the genitals and the area around the buttocks) for Resident 19. This failure violated Resident 19's right to personal privacy and dignity, exposed Resident 19's private area to Resident 19's roommate (Resident 10) and caused both Residents 10 and 19 felt uncomfortable. Findings: During a review of Resident 19's Admission Record (AR), the AR indicated the facility admitted Resident 19 on 4/13/2024, and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin), and heart failure (a condition in which the heart can't pump enough blood to meet the body's needs). During a review of Resident 19's History and Physical (H&P), dated 12/21/2023, the H&P indicated Resident 19 had the mental capacity to make medical decisions. A review of Resident 19's Minimum Data Set (MDS - a resident assessment and care planning tool) dated 11/16/2017, the MDS indicated the resident was moderate impairment of cognitive skills for daily decision making. The resident required extensive assistance with one-person physical assistance with bed mobility, dressing, toilet use, and personal hygiene. During an observation on 2/25/2025 at 2: 40 PM, in Resident's 19's room, Certified Nurse Assistant (CNA) 18, CNA 18 was assisting Resident 19 with perineal care without closing the privacy curtain. Resident 19's roommate (Resident 10) was sitting in Resident 10's wheelchair and was uncomfortable due to the lack of privacy. During an interview on 2/25/2025 at 2:50 PM with CNA 18, CNA 18 stated she forgot to pull the privacy curtain while providing peri care for Resident 19. CNA 18 stated she should have pulled the privacy curtain to maintain Resident 19's privacy during perineal care. During an interview on 2/25/2025 at 2:55 PM with Resident 19, Resident 19 stated that she felt uncomfortable being exposed like that. During a review of Resident 10's AR. The AR indicated the facility admitted Resident 10 on 3/20/2018 and readmitted on [DATE] with diagnoses including urinary tract infection, and muscle weakness. During an interview on 2/25/2025 at 2:57 PM with Resident 10, Resident 10 stated in a foreign language that she felt uncomfortable seeing her roommate (Resident 19) like that. Resident 10 stated that she wishes CNA 18 would have closed the privacy curtain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 4:21 PM with RN 1, RN 1 stated CNA 18 needed to maintain Resident 19's privacy during peri care by pulling the privacy curtain. During a review of the facility's undated policy titled, Dignity, the policy indicated Staff will promote, maintained protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46779 Based on interview and record review, the facility failed to implement the facility ' s policy and procedure titled, Grievance/Concern, dated 8/25/2021, to ensure prompt receipt and resolution of Resident/Representative grievance/concern by failing to: 1. Ensure that information on how to file a grievance or complaint was made available to the resident in accordance with the facility's policy and procedure (P&P) titled Grievance/Concern by posting the information on each unit's prominent locations. 2. Provide prompt efforts to resolve the grievances and provide a written copy of the grievance resolutions (10/3/2024, 10/11/2024, 10/16/2024, 10/21/2024 and 10/22/2024) for one of five sampled residents (Resident 44) reviewed for grievances during the Resident Council Meeting. These deficient practices had the potential to result in the violation of the residents' rights to have his or her grievance addressed due to lack of information in how to file a grievance and had resulted in Resident 44's grievance not being acted upon and not communicated as to what actions were taken to resolve the grievance. Findings: During a review of the facility ' s P&P titled, Grievance/Concern, dated 8/25/2021, the P&P indicated the facility To enusre prompt receipt and resolution of Resident/Representative grievance/concern and A description of the procedure for voicing grievances/concerns will be on each unit in a prominent location. The P&P also indicated the facility to provide written resolution for Civil Rights grievances and upon request for all other grievance by giving a copy of the Grievance/Concern Form to the resident/resident representative. During a review of Resident 44 ' s Admission Record (AR), the AR indicated the facility originally admitted Resident 44 on 6/6/2019 and readmitted him on 9/10/2024 with diagnoses that included diabetes mellitus (A group of diseases that result in too much sugar in the blood) and hypertension (high blood pressure). During a review of Resident 44 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/6/2024, the MDS indicated Resident 44 had intact memory and cognition (ability to think and reason). The MDS indicated Resident 44 was independent with eating, oral hygiene, toileting hygiene, personal hygiene, and chair/bed-to-chair transfer, and required setup or clean-up assistance with shower/bathe self. During a review of the facility ' s Resident Grievance/Complaint Log, the log indicated Resident 44 filed multiple grievances on 10/3/2024, 10/11/2024, 10/16/2024, 10/21/2024 and 10/22/2024. During a review of the facility ' s Resident Grievance/Complaint Log, dated 10/21/2024, the Grievance Log indicated Resident 44 filed a grievance on 10/21/2024, date parties informed of findings was 10/25/2024 and the disposition of the complaint was to follow up with the resident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 44 ' s Grievance/Complaint Resolution Report, dated 10/21/2024, the report indicated Resident 44 complained it was taking a long time for the Colonoscopy (a medical procedure involving the endoscopic examination of the large bowel and the distal portion of the small bowel) appointment. The Report indicated the additional resolution/action plan was that the authorization was obtained on 10/24/2024, and the [NAME] President of Operation spoke to the resident on 10/25/2024. During a review of Resident 44 ' s Progress Notes, dated 10/25/2025 at 10:32 AM, the Progress Notes indicated the gastrointestinal (GI) doctor (a doctor who specializes in digestive system) on Resident 44 ' s authorization was not affiliated with the clinic and new authorization to see a GI doctor was needed. During a review of Resident 44 ' s Progress Notes, dated 10/25/2025 at 3:01 PM, the Progress Notes indicated the Social Services Director informed Resident 44 that copies of grievances will be provided to him on a later date. During an interview on 2/25/2025 at 3:05 PM, Resident 44 stated the information in how to file a grievance was not posted in each unit. Resident 44 stated he filed multiple grievances in 10/2024, and he requested a written copy of his grievances to the facility staff, but he had never received any copy of his grievance resolutions. During an interview on 2/27/2025 at 4:20 PM, Resident 44 stated one of his grievances that he filed in 10/2024 was to see a GI doctor and to schedule a coloscopy, but he had not received a verbal or written resolution for that grievance until now. During a concurrent interview and record review on 2/27/2025 at 4:55 PM, with the Social Service Director (SSD), the facility ' s Resident Grievance/Complaint Log, dated 10/21/2024, and Resident 44 ' s Grievance/Complaint Resolution Report, dated 10/21/2024, were reviewed. The SSD stated the log indicated Resident 44 ' s grievance, dated 10/21/2024 was to follow up with the resident. The SSD stated she did not know that Resident 44 ' s grievances were filed in 10/2024 and did not know that was not resolved. The SSD stated she did know that Resident 44 was still waiting for his GI doctor ' s appointment. The SSD stated she started to work in the facility in the mid of 12/2024 and she did not get endorsement of the unresolved grievances from the other staff. The SSD stated she thought the previous SSD would have resolved all the grievances filed in 10/2024 by 12/2024. The SSD stated the facility should have follow up with Resident 44 ' s unresolved grievances to ensure the resident ' s concern was addressed and resolved. The SSD stated if the resident requested a written copy of the grievance resolution, the SSD should provide a written copy to the resident. During an observation on 2/28/2025 at 4:01 PM, there was no posting of the information in how to file a grievance in Station 2. During a concurrent observation and interview on 2/28/2025 at 4:05 PM, with Registered Nurse (RN) 2, RN 2 stated there was no posting of how to file a grievance in Station 1 for the residents and the family members to see. During a concurrent observation and interview on 2/28/2025 at 4:10 PM, with Treatment Nurse (TXN) 5, TXN 5 stated there was no posting of information in how to file a grievance in Station 3 for the residents and family member to see and know about the grievance process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/28/2025 at 4:15 PM, there was no posting of the information in how to file a file a grievance in Station 4. During an interview on 2/28/2025 at 5 PM, with the Administrator (ADM), the ADM stated there was one posting of the information about how to file a grievance in the hallway from the lobby to the resident care area. The ADM stated there was no other posting of the information in how to file a grievance in each unit of the facility. The ADM the facility should post the information on how to file a grievance and the process on each unit ' s prominent locations for the residents and the family member to view so they could address their concerns to the facility proper and effectively.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 he facility failed to complete a significant change Minimum Data Set ([MDS] a resident assessment tool) assessment after Resident 128's fall on 12/23/2024 which resulted in a left shoulder fracture (break in bone). This failure resulted in the facility's failure to develop and implement interventions to Resident 128's care plan to prevent another fall. Cross reference F656 and F689. Findings: During a review of Resident 128's Admission Record, the facility admitted Resident 128 on 10/19/2023 with diagnoses including Type 2 Diabetes Mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), chronic (long-standing) kidney disease, presence of a right artificial shoulder joint, muscle weakness, and history of falling. During a review of Resident 128's MDS, dated [DATE], the MDS indicated Resident 128 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 128 was independent with eating, oral hygiene, toileting, transferring from lying in bed to the side of the bed, transferring from sitting to standing, transferring from the chair/bed-to-chair, and walking 150 feet using a walker. During a review of Resident 128's Change in Condition Evaluation (CICE), dated 12/23/2024 and completed by Registered Nurse 1 (RN 1), the CICE indicated Resident 128 was found lying on the floor next to the bed. The CICE indicated Resident 128 slid off the bed, landed on the left shoulder, and complained of pain to the left elbow and left shoulder. The CICE indicated Resident 128's physician ordered for Resident 128 to transfer to the General Acute Care Hospital (GACH). During a review of Resident 128's GACH X-ray (image of the inside of the body) report, dated 12/23/2024, the X-ray report indicated Resident 128 had a left proximal (closer to the center of the body) humerus (shoulder bone) fracture. During a review of Resident 128's Interdisciplinary (IDT) Care Conference, dated 12/30/2024, the IDT Care Conference indicated Resident 128 required assistance with bed mobility, ambulation, dressing, and hygiene. The IDT Care Conference recommendations included a Rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) Referral and to update the care plan to prevent recurrence. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 128's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation, dated 12/31/2024, the OT Evaluation indicated Resident 128 was seated at the edge of the bed, slipped while standing up, and fell on [DATE]. The OT Evaluation indicated Resident 128 was referred to OT due to a decline in the ability to move without pain, ability to perform activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), range of motion ([ROM] full movement potential of a joint [where two bones meet]), and strength. During a review of Resident 128's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 1/6/2025, the PT Evaluation indicated Resident 128 slipped on powder on the floor and fell on [DATE]. The PT Evaluation indicated Resident 128 was referred to PT due to the fall and was a fall risk, a decline in functional mobility, limitation with ambulation (the act of walking), and limited and painful movement. During a concurrent observation and interview on 2/27/2025 at 2:03 PM with Resident 128, Resident 128 was sitting on a bench located in the grass lawn next to the facility's parking lot. Resident 128 had a rollator walker (assistive walking device with four wheels, wheel brakes, and a seat) next to bench. Resident 128 stated he slipped on powder, which was used for a rash, that was on the floor, fell directly next to the bed, and broke the left arm about eight weeks ago. During a review of the Resident Assessment Instrument (RAI) Manual, revised 10/2023, page 2-24, the RAI Manual indicated a significant change assessment was completed when there was a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff, impacts more than one area of the resident's health, and required an interdisciplinary review and/or revision of the care plan. During an interview and record review on 2/28/2025 at 6:32 PM with the Acting Director of Nursing (ADON), the ADON reviewed Resident 128's MDS assessments and the RAI Manual, revised 10/2023, regarding the significant change assessment. The ADON stated the purpose of the MDS (in general) included the development of a resident's care plan. The ADON stated Resident 128's left shoulder fracture was a significant change of condition and met the criteria for a significant change assessment. The ADON stated the facility was supposed to but did not complete a significant change of condition assessment within 14 days of Resident 128's left shoulder fracture on 12/23/2024 (two months ago). The ADON stated the significant change of condition assessment would have prompted the facility to update Resident 128's care plans, including the care plan for falls.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for three of four sampled residents (Resident 43, Resident 128, and Resident 54) in accordance with the facility's policy and procedure on Care Plan Comprehensive by failing to: 1. Develop a care plan for Resident 43's psychotropic medications, Lithium and Risperidone (medications that affects mood and behavior) since 11/27/2024. This failure had the potential for Resident 43 not to receive monitoring and interventions related to the adverse (undesired) side effects of psychotropic medications. 2. Develop a care plan for Resident 128 after a fall, resulting in a left shoulder fracture (break in bone) on 12/23/2024. This failure had the potential for Resident 128 to experience another fall which could lead to further physical injury. 3. Develop a care plan for Resident 54 that included interventions related to oxygen use. This failure had a potential to result in Resident 54's not receiving appropriate care, treatments and interventions for her oxygen use. Findings: A review of the facility's policy and procedure titled, Care Plan Comprehensive, dated 8/25/2021, indicated the facility 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. 1. During a review of Resident 43's Admission Record (AR), the AR indicated the facility originally admitted Resident 43 on 10/19/2021 and readmitted on [DATE] with diagnoses that included schizophrenia (a chronic mental disorder characterized by disruptions in thought processes, perceptions, emotions, and social interactions) and bipolar disorder (a mental illness that involves extreme shifts in mood, energy, and activity levels). During a review of Resident 43's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/16/2024, the MDS indicated Resident 43 had intact memory and cognition (ability to think and reason). The MDS indicated Resident 43 was independent with eating, oral hygiene, toileting hygiene, personal hygiene, and chair/bed-to-chair transfer, and required supervision or touching assistance with shower/bathe self. The MDS indicated Resident 43 exhibited delusions (misconceptions or beliefs that are firmly held, contrary to reality). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43's Order Summary Report, dated 2/28/2025, the Report indicated the physician ordered to administer Lithium (medications used to stabilize mood) 300 milligram (mg) one tablet by mouth two times a day for bipolar disorder manifested by (m/b) verbal outburst, starting on 11/27/2024. The Report further indicated the physician ordered to administer Risperidone (medication used to treat intense mood such as severe sadness and mania [overly joyful behavior]) two mg one tablet by mouth at bedtime for psychosis (a mental health condition characterized by a loss of contact with reality) manifested by verbalization of sadness, starting on 11/27/2024. During a review of Resident 43's Medication Administration Record (MAR), dated 2/2025, the MAR indicated Resident 43 received Lithium 300 mg by mouth twice a day and Risperidone two mg by mouth at bedtime. During an interview on 2/28/2025 at 2:58 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated only the registered nurses initiates the care plan for the residents upon admission and readmission, and the LVNs does not initiate resident's care plans. LVN 1 stated she does not know why there was no care plan for Resident 43 to address care and monitoring related to psychotropic medications, Lithium and Risperidone therapy. During a concurrent interview and record review on 2/28/2025 at 3:03 PM with RN 1, Resident 43's Care Plan was reviewed, RN 1 stated Resident 43 had been taking Lithium and Risperidone since 11/27/2024, but the licensed nurses did not develop the care plan to address the use of psychotropic medications for Lithium and Risperidone. RN 1 stated all licensed nurses, including LVNs and RNs could initiate a care plan. RN 1 stated the licensed nurse who received the order for Lithium and Risperidone on 11/27/2024 should have developed the care plan to address care and monitoring for the use of these two psychotropic medications, and for the staff to care for the resident effectively, including monitor for adverse effects of the medications and the resident's response to the medications. During an interview on 2/28/2025 at 7:15 PM with the Acting Director of Nursing, the ADON stated all licensed nurse could and should develop a care plan for residents who were on psychotropic medications. 36943 2. During a review of Resident 128's AR, the AR indicated the facility admitted Resident 128 on 10/19/2023 with diagnoses including Type 2 Diabetes Mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), chronic (long-standing) kidney disease, presence of a right artificial shoulder joint, muscle weakness, and history of falling. During a review of Resident 128's MDS, dated [DATE], the MDS indicated Resident 128 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 128 was independent with eating, oral hygiene, toileting, transferring from lying in bed to the side of the bed, transferring from sitting to standing, transferring from the chair/bed-to-chair, and walking 150 feet using a walker. (continued on next page)

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	056487	A. Building B. Wing	03/01/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 128's Change in Condition Evaluation (CICE), dated 12/23/2024 and completed by Registered Nurse 1 (RN 1), the CICE indicated Resident 128 was found lying on the floor next to the bed. The CICE indicated Resident 128 slid off the bed, landed on the left shoulder, and complained of pain to the left elbow and left shoulder. The CICE indicated Resident 128's physician ordered for Resident 128 to transfer to the General Acute Care Hospital (GACH). During a review of Resident 128's GACH X-ray (image of the inside of the body) report, dated 12/23/2024, the X-ray report indicated Resident 128 had a left proximal (closer to the center of the body) humerus (shoulder bone) fracture. During a review of Resident 128's Census List (record of hospitalization s, room changes, and payer source changes), the Census List indicated Resident 128 returned to the facility on [DATE]. During a review of Resident 128's Interdisciplinary Team (IDT) Care Conference, dated 12/30/2024, the IDT Care Conference indicated the Director of Nursing (DON), previous Assistant Director of Nursing ([NAME]), Social Services Director (SSD), and the Assistant Director of Rehabilitation (ADOR) attended the IDT Care Conference for Resident 128's fall incident. The IDT Care Conference did not include Resident 128 as an attendee. The IDT Care Conference indicated Resident 128 required assistance with bed mobility, ambulation, dressing, and hygiene. The IDT Care Conference recommendations included a Rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) Referral and to update the care plan to prevent recurrence. During a review of Resident 128's care plan for An actual fall with (Specify: No Injury, Minor Injury, Serious Injury) Poor Balance, initiated 12/31/2024, the care plan goals and interventions were blank without any indication of goals and interventions. During a concurrent observation and interview on 2/27/2025 at 2:03 PM with Resident 128, Resident 128 was sitting on a bench located in the grass lawn next to the facility's parking lot. Resident 128 had a rollator walker (assistive walking device with four wheels, wheel brakes, and a seat) next to the bench. Resident 128 stated he slipped on powder, which was used for a rash, that was on the floor, fell directly next to the bed, and broke his left arm about eight weeks ago. Resident 128 stated he already had a right shoulder replacement prior to living at the facility and stated the left arm did not feel the same after the shoulder fracture despite receiving therapy services. During an interview on 2/28/2025 at 8:21 AM in Resident 128's room, Resident 128 stated the facility staff did not discuss the recent fall with Resident 128 and he did not attend the facility's IDT Care Conference on 12/30/2024. During a concurrent interview and record review on 2/28/2025 at 12:07 PM with RN 1, Resident 128's CICE, dated 12/23/2024, X-ray report, dated 12/23/2024, IDT Care Conference, dated 12/30/2024, and care plan for actual fall, initiated 12/31/2024, were reviewed. RN 1 stated Resident 128 usually sat at the edge of the bed and was found on the ground after sliding off the edge of the bed. RN 1 stated Resident 128's physician ordered for Resident 128 to transfer to the GACH and was found to have a left shoulder fracture. RN 1 reviewed Resident 128's care plan for actual fall, initiated 12/31/2024 (after the IDT Care Conference), and stated Resident 128's care plan did not include any interventions and was left blank. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/28/2025 at 12:35 PM with the SSD and RN 1, Resident 128's IDT Care Conference, dated 12/30/2024, was reviewed. The SSD did not remember whether Resident 128 was present for the IDT Care Conference. The SSD stated the IDT Care Conference note did not indicate Resident 128 attended. Both the SSD and RN 1 described Resident 128 as very alert. During an interview on 2/28/2025 at 12:46 PM with RN 1, RN 1 stated the facility should have included Resident 128 in the IDT Care Conference and stated the IDT should have developed interventions to prevent further falls. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, revised 8/25/2021, the P&P indicated the facility's IDT in coordination with the resident must develop and implement a comprehensive person-centered care plan that includes measurable objectives. The P&P indicated the comprehensive care plan was designed to aid in preventing or reducing declines in the resident's functional status. 47467 3. During a review of Resident 54's AR, the AR indicated Resident 54 was initially admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses that included bronchopneumonia [a type of pneumonia (an infection of one or both of the lungs) that causes inflammation of the air tubes in the lungs]. During a review of Resident 54's History and Physical Examination (HPE), dated 1/21/2025, the HPE indicated Resident 54 had fluctuating capacity to understand and make decision. During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 54's cognition (ability to think, remember, and reason with no difficulty) was moderately impaired and needed set up or clean up assistance in eating and oral hygiene. During a review of Resident 54's Order Summary Report (OSR), for February 2025, the Report indicated on 2/25/2025, Resident 54 had a physician order for oxygen therapy via nasal cannula (a flexible tube that provides oxygen through the nose) at 3 L/min [liters (unit of volume) per minute (unit of time)] for shortness of breath and to maintain oxygen saturation (measures how much oxygen blood carries in comparison to its full capacity) above 93% every 4 hours as needed. During a concurrent observation and interview on 2/25/2025 at 10:26 AM in Resident 54's room, Resident 54 was observed lying in bed. During the observation, an oxygen supplement device was observed running and connected with a nasal cannula on the floor. Resident 54 stated, the nasal cannula was for Resident 54's oxygen use, and the resident did not know why it was on the floor. During a concurrent record review and interview on 2/25/2025 at 10:35 AM with Licensed Vocational Nurse (LVN) 7, Resident 54's physician orders and care plans were reviewed. LVN 7 stated, Resident 54 had a physician order for oxygen therapy to make sure her oxygen saturation was maintained above 93%. LVN 7 stated, she could not find any care plans developed with interventions for Resident 54's oxygen use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/28/2025 at 4:29 PM with the Acting Director of Nursing (ADON), the ADON stated, it was important to develop a care plan with interventions to monitor the resident for oxygen use because it was part of the resident's overall care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on interview and record review, the facility failed to revise a care plan for one of one sampled resident (Resident 491) who was identified as at risk for fall since admitted to the facility on [DATE]. This failure resulted in Resident 491 sustaining three recurrent falls from his bed within two weeks and has the potential to place Resident 491 for recurrent falls. Crossed reference with F689 Findings: During a review of Resident 491's Admission Record, the facility admitted Resident 491 on 2/14/2025 with diagnoses which included acute respiratory failure (ARF, when the lungs have trouble getting enough oxygen [odorless gas needed for plant and animal life] into the blood) with hypoxia (condition where the body's tissues doesn't have enough oxygen), unspecified atrial fibrillation (a heart condition that caused an irregular heart beat), and other abnormalities of gait (the pattern a person walks) and mobility. During a review of Resident 491's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 2/15/2025, the H&P indicated Resident 491 does have the capacity to understand and make decisions. During a review of Resident 491's Minimum Data Set (MDS, a federally mandated resident assessment), dated 2/20/2025, indicated Resident 491's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was severely impaired. The MDS indicated Resident 491 required moderate assistance (helper does less than half the effort) when transferring from sitting to lying in bed, lying to sitting on the side of the bed and the ability to sit to stand from the chair. The MDS indicated Resident 491 was frequently incontinent (involuntary loss of bladder or bowel control) of urine and stool. The MDS indicated Resident 491 did not have any history of falls prior to admission to the facility. During a review of Resident 491's care plan, dated 2/15/2025, the care plan indicated Resident 491 was at risks for falls related to confusion, gait (the way a person walks) balance problems. The care plan goals indicated the resident will be free of falls by target date 5/16/2025. The care plan interventions included anticipating and meeting the residents needs and ensuring the resident's call light was within reach. During a review of Resident 491's Nursing Documentation Evaluation document, dated 2/15/2025, the document indicated Resident 491's had a risk factor of falls related to disorientation and confusion. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 491's Change in Condition Evaluation (CoC) document, dated 2/18/2025, LVN 5 indicated Resident 491 had episodes of confusion and was found crawling on the floor. LVN 5 indicated the bed was in the lowest position with floor mat next to the bed. During a review of Resident 491's care plan, dated 2/18/2025, the care plan indicated Resident 491 was at risk for falls due to episodes of confusion and crawling on the floor. The care plans goals indicated the resident will have no falls by the target date of 5/16/2025. The care plans interventions included providing verbal safety reminders, placing the call light within reach, and monitoring for and assisting Resident 491 with toileting needs. During a review of Resident 491's Nursing Progress Notes, dated 2/19/2025, Licensed Vocational Nurse (LVN) 11 indicated at 3:30PM on 2/19/2025, Resident 491 was crawling on the floor. LVN 11 indicated one to one staffing was provided. During a concurrent record review and interview on 2/28/2025 at 5:38PM with Registered Nurse (RN) 1, Resident 491's fall risk care plan titled (Resident 491) was at risk for falls related to confusion, gait/balance dated 2/15/2025 was reviewed. RN 1 stated, this care plan was last revised on 2/15/2025. During a concurrent record review and interview on 2/28/2025 at 5:38PM with RN 1, Resident 491's fall risk care plan titled (Resident 491) was at risk for falls due to episodes of confusion and crawling on the floor dated 2/18/2025 was reviewed. RN 1 stated, this care plan was last revised on 2/18/2025. During an interview on 2/28/2024 at 5:38PM with RN 1, stated, Resident 491's care plans related to his risk of falls and his recent episodes of being found crawling on the ground were not revised. RN 1 stated, Resident 491 had two previous episodes of being found crawling on the ground, therefore it was important to re-evaluate the effectiveness of the current interventions. RN 1 stated, if the current interventions were not effective, it was important to make revisions and identify different interventions that may be implemented to improve Resident 491's safety and care. RN 1 stated care plans were guidelines of how nurses provide individualized care towards their residents. During a review of the facility's policies and procedures (P&P), titled Fall Management, dated 5/26/2021, the P&P indicated to communicate the patient's fall risk status to the caregivers. The P&P indicated to develop an individualized plan of care and to review and revise care plan as indicated. During a review of the facility's P&P, titled Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the interventions should address the underlying source of the problem areas, rather than addressing only symptoms or triggers. During a review of the facility's P&P, titled Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the assessment of residents are ongoing, and care plans are reviewed and revised as information about the resident and the resident's condition change. During a review of the facility's P&P, titled Care Plan Comprehensive, dated 8/25/2021, the P&P indicated the Interdisciplinary team was responsible for evaluating and updating of care plans when there has been a significant change in the resident's condition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 36943 Based on observation, interview, and record review, the facility failed to provide one of three sampled residents (Resident 130) with care and services to residents unable to carry out Activities of Daily Living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) independently in accordance with the care plan. This deficient practice resulted to Resident 130 verbalizing feelings of helplessness and had the potential to result in skin redness and irritation to Resident 130 ' s skin due to the facility ' s inability to attend timely to the resident ' s perineal care needs. Findings: During a review of the facility ' s policy and procedure (P&P) titled, Activities of Daily Living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), supporting, revised on 3/2018, the P&P indicated resident will be provided with care, treatment, and services to residents unable to carry out ADLs independently in accordance with the care plan. During a review of the facility ' s P&P titled, Answering the Call Light, revised 10/24/2024, the P&P indicated the facility would ensure timely responses to the resident ' s requests and needs. The P&P indicated to answer the call system and if the resident ' s request is something you can fulfill, complete the task within five minutes if possible. During a review of Resident 130 ' s Admission Record (AR), the AR indicated the facility admitted Resident 130 on 12/4/2024 with diagnoses including cervical spondylosis (condition of age-related wear and tear affecting the spinal discs in the neck) with myelopathy (condition that affects the spinal cord causing damage or compression), cervical spine fusion (surgical procedure that joins two or more discs in the neck), abnormalities of gait (manner of walking) and mobility (ability to move), muscle weakness, and lack of coordination. During a review of Resident 130 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 12/10/2024, the MDS indicated Resident 130 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 130 had range of motion ([ROM] full movement potential of a joint [where two bones meet]) limitations in one arm and one leg, required substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing, transfers from lying in the bed to sitting on the side of the bed, transfers from chair/bed-to-chair, and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for toileting hygiene. During a review of Resident 130 ' s care plan titled, Resident has episodes of bowel and bladder incontinence, created on 12/18/2024, the care plan interventions included to assist with perineal care as needed, monitor for skin redness/irritation, and provide privacy and comfort. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 4:18 PM in Resident 130 ' s room, Resident 130 was fully dressed, sat in the wheelchair, and propelled the wheelchair using both legs. Resident 130 stated he pushed the call light this morning (did not specify time) to have his incontinence brief changed. Resident 130 stated Certified Nursing Assistant 2 (CNA 2) came to the room, and informed the resident, she would assist Resident 130, but CNA 2 did not return for one-and-a-half hours (1.5 hours). During a telephone interview on 2/26/2025 at 2:59 PM with CNA 2, CNA 2 stated Resident 130 pushed the call light on 2/25/2025 at approximately 12:15 PM requesting to change the incontinence brief. CNA 2 stated the call light was turned off and returned at approximately 12:45 PM, because CNA 2 helped another resident who was about to fall. CNA 2 stated Resident 130 should not have been waiting that long to change a wet incontinence brief. During a follow-up telephone interview on 2/26/2025 at 3:43 PM with CNA 2, CNA 2 stated she did not know the reason another CNA did not assist Resident 130. During an interview on 2/27/2025 at 8:28 AM with Resident 130, Resident 130 stated he pushed the call light again, while waiting for CNA 2 on 2/25/2025, and a staff member (unknown) came to answer the call light. Resident 130 stated the staff member told him that CNA 2 was assigned to his care and were unable to assist Resident 130. Resident 130 stated he felt bad waiting a long time without assistance while wearing a wet incontinence brief. Resident 130 stated he had skin redness after wearing the wet incontinence brief, which has resolved since the incident (on 2/25/2025). During an interview on 2/27/2025 at 3:40 PM with the Administrator (ADM), the ADM stated a resident (in general) could develop skin irritation if a wet incontinence brief remained on a resident for more than 20 minutes. The ADM stated it was not appropriate for the staff to respond to the call light and deny care because the resident was not assigned to the staff member.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation, interview, and record review, the facility failed to ensure 4 of 9 residents reviewed with pressure ulcer (Resident 186, 9, 121 and 55) received treatment and services to protect skin integrity (the state of skin being intact, healthy, and free from damage), promote healing, and prevent the development and worsening of pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to ensure: 1. Resident 186, who did not have a pressure ulcer on admission to the facility, developed a Stage 2 (partial-thickness of skin, presenting as a shallow open sore or wound) coccyx (tailbone) pressure ulcer that worsened to a Stage 3 pressure ulcer (full-thickness loss of skin, dead and black tissue may be visible). In addition, the resident developed a left heel vascular ulcer (an open sore developed due to problems with poor blood circulation) while in the facility. 2a. Resident 121's, who had a healed Stage 4 pressure ulcer (skin damage due to unrelieved pressure of all layers of the skin, reaching the underlying muscle, tendon, or bone, often with exposed tissue and a high risk of infection) on the sacral, Low Air loss Mattress (LAL, distributes the resident's body weight over a broad surface area and help prevent skin breakdown) was not set based on the resident's weight of 150 pounds (lbs.) and was not checked every shift for setting, connection, and functioning as ordered by the physician. 2b. Resident 9's, who had a healed Deep Tissue Injury (DTI, skin damage due to unrelieved pressure beneath the skin that may appear purple or maroon, or with blood-filled blister) on the ischium (lower and back part of the hip), the LAL mattress was not set based on the resident's weight of 101 lbs. and was not checked every shift for setting, connection, and functioning as ordered by the physician. 3. Resident 55, who had a Stage 4 pressure ulcer on the right ischium, the facility had no obtain records from the wound specialist regarding the resident's wound condition and treatment recommendation since 1/23/2025. In addition, there was no weekly skin and wound assessment documentation in Nursing Progress Notes and Interdisciplinary Team report of the resident's wound condition after 1/23/25. These deficient practices resulted in the development of pressure ulcer for Resident 186 and the potential to result in the recurrent development of pressure ulcers and/or worsening of pressure that could lead to pain, discomfort and infection for Residents 121, 9 and 55. Findings: 1. During a review of Resident 186's Admission Record, indicated the facility admitted Resident 186 on 1/31/2025 with diagnoses that included acute respiratory failure (ARF, when the lungs have trouble getting enough oxygen [odorless gas needed for plant and animal life] into the blood) with hypoxia (not enough oxygen in the body's tissues, muscle weakness, and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 186's History and Physical (H&P, a comprehensive physician's note regarding the assessment of a resident's health status), dated 1/31/2025, Resident 186 had the capacity to understand and make decisions. The H&P indicated Resident 186 had no skin breakdown and skin was intact. During a review of Resident 186's Body Check document, dated 1/31/2025, indicated Resident 186 did not have any skin breakdown. During a review of Resident 186's Braden Scale for Predicting Pressure Sore Risk Original (a standardized and evidence-based assessment tool to assess a resident's risk of developing pressure ulcers), dated 1/31/2025, indicated Resident 186 was at mild risk for developing pressure ulcer due to the resident's skin was occasionally moist, and makes small frequent movement while confined to bed. During a review of the Nursing Progress Notes, dated 2/1/2025, Treatment Nurse (TXN) 2 indicated Resident 186 had a coccyx (tailbone) Stage 2 pressure ulcer (partial-thickness loss of skin, presented as a shallow open sore or wound) sized 2 centimeters (cm, unit of measure) by 2 cm by 0.1 cm, with 100% pink wound bed. During a review of Resident 186's Order Summary Report (physician's orders), dated 2/1/2025, indicated to clean Resident 186's coccyx pressure ulcer with normal saline, pat dry, apply [NAME]-honey (sterile, medical grade honey dressing used to treat wounds), and cover with foam dressing every day, every shift. During a review of Resident 186's care plan, date initiated on 2/1/2025, the care plan indicated Resident 186 had an actual skin breakdown on her coccyx pressure. The care plans interventions, dated 2/1/2025, included to turn or reposition the resident for comfort as tolerated, observe for signs and symptoms of skin breakdown such as redness, decrease sensation, and if skin that does not blanche easily, and to observe for verbal and nonverbal signs of pain related to wound treatment. During a review of Resident 186's care plan, date initiated on 2/5/2025, the care plan indicated Resident 186 missed her treatment that included Coccyx pressure ulcer cleanse with NS, pat dry, apply thera-honey, cover with foam dressing every day shift for 30 days until finished Bilateral lower extremity apply A&D ointment x dry scaley skin every day for 30 days until finished to bilateral legs and coccyx 2/4/2025. The care plan's interventions included monitor vital signs every shift, provide treatment as ordered, and call the physician for any changes of condition. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 186's Minimum Data Set (MDS, a resident assessment), dated 2/6/2025, the MDS indicated Resident 186's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was intact. The MDS indicated Resident 186 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily), and Resident 186 required substantial assistance (helper does more than half the effort) to turn from her back to the left or right side and to return to lying on her back on the bed. The MDS indicated Resident 186 was always incontinent (involuntary loss of bladder or bowel control) for urine and stool. The MDS indicated Resident 186 was at risk for developing pressure ulcers, and Resident 186 had one Stage 2 pressure ulcer present upon admission. The MDS indicated Resident 186's skin and pressure ulcer treatments included a pressure reducing device for the bed, pressure ulcer care, and the application of ointment or medication to the pressure ulcer. During a review of Resident 186's Order Summary Report, dated 2/6/2025 the physician ordered Resident 186 to be seen by wound consult (a physician specialized in wound care and pressure ulcers). During a review of Resident 186's Wound Assessment, dated 2/6/2025, evaluated by Physician Assistant (PA) 1, PA 1 indicated Resident 186 had a Stage 2 pressure ulcer on her coccyx measured 2.0 cm by 2.0 cm by 0.1 cm with light serosanguinous (thin watery fluid pink in color) drainage. PA 1 indicated Resident 186's pressure ulcer wound edges were macerated (a process where the skin becomes softened and breaks down due to prolonged exposure to moisture) and easily irritated. During a review of Resident 186's Wound Assessment, dated 2/13/2025, evaluated by PA 1, PA 1 indicated Resident 186's coccyx Stage 2 pressure ulcer measured 2.0 cm by 2.0 cm by 0.2 cm. PA 1 indicated Resident 186 had a serial surgical debridement (a medical procedure to clean a wound by removing the dead or damaged tissue). PA 1 indicated Resident 186's pressure ulcer remeasurement was 2 cm by 2 cm by 0.3 cm and reclassified as a Stage 3 pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible). PA 1 indicated Resident 186 had multiple comorbidities (two or more conditions occurring at the same time) and a high Braden score resulting in high risk for wound decline and delayed wound healing. PA 1 indicated Resident 186's coccyx pressure ulcer wound edges were macerated and easily irritated with light serosanguinous drainage noted. During a review of Resident 186's Change of Condition (CoC) document, dated 2/13/2025, the CoC indicated PA 1 examined Resident 186 and reported Resident's coccyx pressure ulcer had declined due to comorbidities. The Primary Care Physician (PCP) 1 recommendations included to continue following PA 1's treatment orders. During a review of Resident 186's care plan, date initiated 2/13/2025, the care plan indicated Resident 186 had been seen by the wound care physician for a decline of wounds related to her comorbidities. The care plan's interventions included continuing wound care treatment plan and to notify physician for any changes. During a review of Resident 186's Braden Scale document, dated 2/14/2025, the Braden Scale indicated Resident 186 was at high risk for developing pressure ulcers due to limited movement and required complete assistance with movement and skin was constantly damped with sweat or urine. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 186's Interdisciplinary Team (IDT, a group of health care professionals with various areas specialties who work together towards the goal of their resident) Care Conference note, dated 2/14/2025, the IDT note indicated Resident 186 had a Stage 3 coccyx pressure ulcer sized 2 cm by 2 cm by 0.3mcm, with 50% pink wound bed and 50% slough (dead tissue that is usually yellow, tan, grey, or green in color, usually moist and stringy in texture, that may be found in wounds), with light serosanguinous drainage, no odor, macerated and easily irritated wound edges. The IDT note wound status indicated Resident 186 Stage 3 pressure ulcer wound status was worsening. The IDT note indicated Resident 186's risk factors included exposure of skin to urinary and fecal incontinence. During a review of Resident 186's Order Summary Report, with an ordered date on 2/14/2025, Resident 186 had an order for a Low Air Loss (LAL, a mattress used to distribute a resident's body weight over a broad surface area and help prevent skin breakdown) mattress for pressure distribution and to monitor the LAL mattress was functioning properly. During a review of Resident 186's Nursing Progress Notes, dated 2/18/2025, TXN 3 indicated Resident 186 was seen by wound consultant on 2/17/2025 and recommended to continue current Stage 3 pressure ulcer treatment. The Nursing Progress Notes indicated a new skin breakdown on the left heel with vascular ulcer (an open sore developed due to problems with poor blood circulation). During a review of Resident 186's Order Summary Report, with an ordered date on 2/18/2025, Resident 186 had an order to cleanse the left heel vascular ulcer with normal saline, pat dry, apply betadine, and cover with dry dressing every day, every shift. During a review of Resident 186's care plan, revised on 2/20/2025, the care plan indicated Resident 186 was incontinent. The care plans interventions included, monitor for skin redness or irritation and to notify the physician and to assist Resident 186 with perineal care (cleaning and caring for the genital and anal areas to maintain hygiene and prevent infections) as needed. During a review of Resident 186's care plan, revised on 2/20/2025, the care plan indicated Resident 186 had actual skin impairment and was at risk for further skin breakdown infection, wound deterioration, and not healing wound. The care plans interventions included assisting Resident 186 with turning and repositioning for comfort and as needed, evaluate for any skin problems, to observe her skin condition daily with ADL cares and report any changes to the physician, to perform weekly skin assessments by the licensed nurse, and to perform weekly wound assessments to include measurements and descriptions of wound status. During a review of Resident 186's care plan initiated on 2/1/2025 and revised on 2/21/2025, the care plan indicated Resident 186 had a Stage 3 coccyx pressure ulcer. The care plans added the interventions to provide Resident 186 with pressure redistribution surface to her bed. The care plan's interventions included turning or repositioning the resident as tolerated, observe skin for signs and symptoms of break down which included redness, cracking, blistering, decrease sensation, and non-blanchable skin (redness that does not fade when pressed), and to provide ordered treatment and observe for signs and symptoms of infection until healed and to report changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 186's IDT note, dated 2/22/2025, the TXN 2 indicated Resident had two identified wounds. Resident 186's first wound was the Stage 3 coccyx wound was 2 cm by 2 cm by 0.3 cm with 70% pink wound bed and 30% slough with moderate serosanguinous drainage, with macerated, thinned, and irritated wound edges. Resident 186's second wound was located on the right heel sized 3 cm by 3 cm by 0.3 cm with 10% pink wound bed, 80% eschar (dead tissue that was hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off) and 10% slough with moderate serosanguinous drainage, with macerated, irritated, and slough wound edges. During a review of Resident 186's Skilled Nursing Facility/Nursing Facility (SNF/NF) to Hospital Transfer Form (Transfer Form), transfer date of 2/24/2025, the Transfer Form there was no documented evidence Resident 186 had any pressure ulcers or wounds at the time of transfer. During an interview on 2/28/2025 at 10:19AM with Registered Nurse (RN) 3, RN 3 stated, it was important to reposition the resident every two hours, place resident on a LAL mattress, and perform regular wound care treatments. RN 3 stated, it was important for the Registered Dietitian (RD) to evaluate the residents and to ensure the residents were ordered the correct supplements to encourage wound healing. During a concurrent interview and record review on 2/28/2025 at 8:30PM with Licensed Vocational Nurse (LVN) 5, Resident 186's Body Check document, dated 1/31/2025, was reviewed. There was no documented evidence Resident 186 had any skin breakdown. Resident 186 did not have any pressure ulcers or skin issues upon admission. During a concurrent interview and record review on 2/28/2025 at 8:30PM with LVN 5, Resident 186's Nursing Documentation Evaluation, dated 1/31/2025, was reviewed. The Nursing Documentation Evaluation indicated Resident 186 did not have any skin issues. LVN 5 stated, this document indicated Resident 186 did not have any skin breakdown. During a concurrent interview and record review on 2/28/2025 at 8:30PM with LVN 5, Resident 186's Weekly Summary Documentation, dated 2/4/2025, was reviewed. The Weekly Summary Documentation indicated Resident 186 did not have any skin issues. LVN 5 stated, this document indicated Resident 186 did not have any skin breakdown. During a concurrent interview and record review on 2/28/2025 at 8:30PM with LVN 5, Resident 186's CoC, dated 2/13/2025, was reviewed. The CoC indicated Resident 186 was seen by a wound consultant and noted with a decline in wound due to comorbidities. LVN 5 stated, she was unaware Resident 186 had any pressure ulcers or skin impairments prior to the PA 1's visit with Resident 186. During a concurrent interview and record review on 2/28/2025 at 8:30PM with LVN 5, Resident 186's Body Check, dated 2/21/2025, was reviewed. LVN 5 stated, there was no documented evidence Resident 186 had a Stage 3 coccyx pressure ulcer or a left heel vascular ulcer. LVN 5 stated Resident 186's skin condition should had been documented in the Body Check weekly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 8:45PM with LVN 5, LVN 5 stated, Resident 186's Transfer form prior to transfer to General Acute Care Hospital (GACH), dated 2/24/2025, there was no indication in the Body Check form that the resident had any skin breakdown. LVN 5 stated, if there was documentation of Resident 186's pressure ulcer the skin would have been monitored, and the wound's decline could have been identified earlier. During an interview on 2/28/2025 at 9 PM with LVN 5, LVN 5 stated, Resident 186's pressure ulcer may have worsened because the resident's briefs were not being changed as often leaving Resident 186 lying in her wet and dirty briefs for a long period of time. LVN 5 also stated, Resident 186 probably was not being repositioned every two hours. LVN 5 stated she was in charge of the documentation and putting in orders and assessments for residents. During an interview on 3/1/2025 at 12 PM with TXN 2, the TXN 2 stated, Resident 186 was probably not turned and repositioned every two hours, and Resident 186's brief was probably not changed as often as it should have been, resulting in the resident lying in the same positioning and in their urine or stool filled briefs for long periods of time. During a concurrent interview and record review on 3/1/2025 at 2:55PM with CNA 9, CNS 9 stated Resident 186's Daily Skin Assessments (the skin assessment form used by the CNAs to document the residents skin condition) dated 2/12/2025, 2/13/2025, 2/14/2025, 2/18/2025, 2/19/2025, 2/20/2025, and 2/21/2025 were reviewed. CNA 9 stated she took care of Resident 186 and upon review the Daily Skin Assessments did not indicate that Resident 186 had pressure ulcers or skin breakdown. CNA 9 stated, it was never reported to her by the Licensed Nurses that Resident 186 had a pressure ulcer. 46779 2a. During a review of Resident 121's Admission Record (AR), the AR indicated the facility admitted Resident 121 on 7/23/2024 and readmitted him on 8/21/2024 with diagnoses that included diabetes mellitus (a group of diseases that result in too much sugar in the blood) and stage four pressure ulcer (the most severe stage of a pressure sore, where the wound extends through all layers of skin to the bone structure) on the sacrum (lower back and upper buttock). During a review of Resident 121's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/6/2025, indicated Resident 121 had moderately impaired memory and cognition (ability to think and reason). The MDS indicated Resident 121 required substantial/maximal assistance with rolling left and right, and was dependent from staff with toileting hygiene, personal hygiene, chair/bed-to-chair transfer. During a review of Resident 121's Order Summary Report, dated 2/28/2025, the report indicated the physician ordered for the resident to have a low air loss mattress and wound management, to check for comfort, setting and connection (functioning properly) every shift, starting on 1/4/2025. During a review of the User Manual for Low Air Loss Mattress System, dated 2018, indicated to turn the pressure adjust knob to a comfortable pressure level using the weight scale. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 9:13 AM, with Licensed Vocational Nurse (LVN) 5, Resident 121 was lying on a LAL mattress. LVN 5 stated, Resident 121's LAL mattress pump had a yellow sticker with a number 150 which indicates the resident weighs 150 pounds. LVN 5 stated, the pressure adjust knob on the LAL mattress pump was set below pounds on the weight scale display panel. LVN 5 stated the number 150 on the yellow sticker indicated the LAL mattress pressure should be set at 150 pounds and the pressure adjust knob should be pointing at 150 on the weight scale. During a concurrent interview and record review on 2/27/2025 at 10:15AM, with Treatment Nurse (TXN) 1, Resident 121's Treatment Administration Record (TAR), dated 1/2025 and 2/2025, were reviewed. TXN 1 stated, there were no documentation to indicated Resident 121's LAL mattress settings, connection, and functions were checked during the morning shift from 7AM to 3PM on 1/17/2025. The TXN 1 stated, there was no documentation to indicated Resident 121's LAL mattress setting, connection, and functions were checked during the evening shift from 3PM to 11PM on 1/8/2025, 1/11/2025, 1/15/2025, 1/17/2025, 1/23/2025, 2/4/2025, 2/23/2025, and 2/24/2025. The TXN 1 stated, there was no documentation to indicate Resident 121's LAL mattress setting, connections, and functions were checked during the night shift from 11PM to 7AM on 1/18/2025, 2/8/2025, 2/14/2025, and 2/19/2025. During an interview on 2/27/2025 at 10:15AM with TXN 1, the physician ordered was to check Resident 121's LAL mattress every shift. TXN 1 stated, the TXN should check the LAL mattress when providing wound care for the resident and document the setting, connections, and functions as completed during the morning shift. TXN 1 stated, the charge nurses were responsible to check the LAL mattress and document for the evening and night shift. During an interview on 2/27/2025 at 10:15AM with TXN 1, TXN 1 stated Resident 121's sacral wound was healed, but Resident 121 was still at high risk for skin breakdown and needed to continue skin treatments to prevent the recurrence of the of the pressure ulcer. TXN 1 stated, it was important to provide comfort and to alleviate pressure on the resident's bony parts to prevent the recurrent pressure ulcer and formation of a new pressure ulcer. During a review of Resident 9's Care Plan Report, dated 1/24/2025, the report indicated the care plan addressed Resident 9's DTI at the left ischium (lower and back part of the hip) and the interventions included pressure redistribution surface (a surface that distributes body weight across a larger area to reduce pressure on the body) to be as guideline for LAL mattress. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severely impaired memory and cognition. The MDS indicated Resident 9 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene, and was dependent with rolling left and right. During a review of Resident 9's Order Summary Report, dated 2/28/2025, the order indicated to clean Resident 9's left ischium DTI with normal saline, pat try, and apply barrier cream for skin maintenance every day for 30 days starting on 2/23/2025. During a review of Resident 9's Order Summary Report, dated 2/28/2025, the order indicated for Resident 9's LAL mattress to check for comfort, setting, and connection every shift, starting on 1/25/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the undated User Manual for Low Air-Loss Mattress, the manual indicated The Pressure Control Knob on the pump should be set to a weight slightly greater than the patient's weight. During a concurrent observation and interview on 2/25/2025 at 10:07 AM, with LVN 2, Resident 9 was lying on a LAL mattress. Resident 9's LAL mattress pump had a yellow sticker written with 80-160 on it. LVN 2 stated Resident 9's recent weigh in February 2025 was 101 lbs. and the current LAL mattress setting was set at set slightly over 160 lbs. which was not the right setting. LVN 2 stated it was important to ensure the air mattress was at the right setting to redistribute the pressure and promote healing and comfort to the resident. During a concurrent observation and interview on 2/27/2025 at 10:20 AM, with TXN 1, Resident 9's TAR, dated 1/2025 and 2/2025, were reviewed. TXN 1 stated, there were no documentation that indicated the nurses checked Resident 9's LAL air mattress during the morning shift from 7 AM to 3 PM on 2/4/2024, the evening shift from 3 PM to 11 PM on 1/29/2025, 1/31/2025, 2/4/2025, 2/16/2025, 2/23/2025, 2/24/2025, and the night shift from 11 PM to 7 AM on 2/1/2025, 2/6/2025, 2/7/2025, and 2/13/2025, 2/15/2025, and 2/18/2025. TXN 1 stated, Resident 9's left ischium wound was healed, but Resident 9 was still at high risk for skin breakdown. TXN 1 stated, it was important to ensure the LAL mattress was at the right setting to provide comfort and to alleviate pressure on Resident 9's bony parts to prevent the recurrent pressure ulcer and the formation of new pressure ulcer. 3. During a review of Resident 55's AR, the AR indicated the facility admitted Resident 55 on 11/23/2019 and readmitted him on 12/16/2024 with diagnoses that included dementia (a decline in mental abilities that can include memory loss, difficulty thinking, and challenges with reasoning) and stage four pressure at right buttock. During a review of Resident 55's Care Plan Report, revised on 10/23/2024, the report indicated the care plan addressed Resident 55's stage four pressure ulcer at right ischium and the interventions included to monitor for further skin breakdown and report to physician as indicated, and weekly skin assessment to include measurements and description of redness status. During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55 had intact memory and cognition. The MDS indicated Resident 55 required setup or clean-up assistance with eating, partial/moderate assistance with personal hygiene, and was dependent with staff on toileting hygiene, chair/bed-to-chair transfer and rolling left and right. During a review of Resident 55's Physician Order, dated 1/23/2025, the order indicated the physician ordered to cleanse the resident's stage four pressure ulcer at right ischium with NS, pat dry, apply collagen powder (a substance applied to wounds to promote wound healing), calcium alginate (a substance used to treat wound), cover with foam dressing as needed for if soiled and every day shift for pressure ulcer at right ischium for 30 days. During a concurrent interview on 2/28/2025 at 10:35AM with TXN 1, TXN 1 stated, Resident 55 was seen by a wound care specialist in the facility every week for his right ischium pressure ulcer. TXN 1 stated, a facility TXN would accompany the wound care specialist to assess and provide wound care treatment for Resident 55 during the visit. TXN 1 stated, the TXN would document the wound assessment, current treatment, and additional wound notes in the Interdisciplinary Care Conference weekly. TXN 1 stated, the Interdisciplinary Care note was considered as the weekly wound assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/28/2025 at 10:36 AM with TXN 1, TXN 1 stated the wound care specialist started to see Resident 55 on 1/6/2025 and the facility did not obtain any wound assessment reports, treatment recommendation and progress notes from the wound care specialist since 1/6/2025. During a concurrent interview and record review on 2/28/2025 at 11:25 AM with TXN 1, Resident 55's Interdisciplinary Care Notes, dated from 1/6/2025 to 2/14/2025, and Resident 55's Progress Notes, dated 1/2025 to 2/2025, were reviewed. TXN 1 stated there was no documentation of wound assessment for Resident 55's pressure ulcer on the right ischium after 1/23/2025. During an interview on 2/28/2025 at 11:30AM with TXN 1, TXN 1 stated, due to a lack of weekly skin/wound assessment in the Interdisciplinary Care Notes and the Nursing Progress notes, there was no indication of the communication with the wound care specialist about Resident 55's wound to indicate the condition of the wound or to evaluate if the current treatment was effective. The TXN 1 stated, it was important to obtain the progress notes from the wound care specialist because the facility staff would be aware of the wound's condition and treatment plan effectiveness. During an interview on 2/28/2025 at 7:13 PM with the Acting Director of Nursing (ADON), the ADON stated the TXNs were supposed to complete a weekly skin/wound assessment in the Interdisciplinary Care Conference note for all the residents with a skin issue or a wound, so the facility could monitor and know the healing progress of the skin and the wound, and intervene if there was a deterioration of the skin condition and the wound. The ADON stated the facility should obtain the progress notes for the residents that were seen by a wound specialist to ensure the consistent wound assessment and wound care were provided to the residents. During a review of the facility's policy and procedure (P&P) titled, Skin Integrity Management, dated 5/26/2021, indicated the facility will provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds and will perform wound observations and measurements upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. The P&P also indicated the facility will: A. Implement an individual patient's skin integrity management when it occurs within the care delivery process. B. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. C. Perform skin inspection on admission, readmission, weekly and document in the Treatment Administration Record and the Point Click Care (a computerized charting system at the facility). D. Nursing staff will observe for any sign of potential injury or active pressure ulcer daily while providing care. E. Develop comprehensive care plan and IDT care plan for prevention and treatments, identify risk factors and determine turning and repositioning based on resident's needs.

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F 0689 Level of Harm - 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** 50012 Based on observation, interview and record review, the facility failed to provide a hazard free environment and adequate supervision (an intervention and means of mitigating the risk for accidents) for three of five sampled (Residents 29, 128 and 491) who were assessed at high risk for falls in accordance with the facility's policy titled, Fall Management, effective 5/26/2021 by failing to: 1. Evaluate and analyze hazard and risk factors to reduce recurrent falls for Resident 29 who had multiple incidents of falls on 10/9/2024, 10/21/2024, 11/6/2024, 11/25/2024 and 11/26/2024. 2. Identify environmental hazard and risk of an accident for Resident 128 who slipped onto the floor due from Nystatin powder (medication to treat fungal or yeast infections of the skin) that was left on the ground. In addition, Resident 128 called for assistance and the resident's call light was not answered immediately after the resident fell on [DATE]. 3. Re-evaluate and provide adequate supervision for Resident 491 to prevent falls, who had been found crawling on the floor on 2/18/2025, 2/19/2025, and 2/26/2025. As a result, Resident 29 sustained a non-displaced (not out of place) acute fracture (sudden and unexpected broken bone due to traumatic event) of the left ankle on 11/27/2024. Resident 128 sustained a fracture (break in bone) of the left proximal (closer to the center of the body) humerus (shoulder bone) on 12/23/2024 resulting in pain, discomfort and decline in mobility. Resident 491 had incidents of being found on the floor that could potentially result in injuries, pain, fractures, hospitalization and a decline in mobility. Cross Reference F-657 Findings: 1. During a review of Resident 29's Admission Record (Face Sheet), indicated Resident 29 was admitted to the facility on [DATE], with diagnoses that included history of falling, muscle weakness, and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). During a review of Resident 29's History and Physical (H&P) dated 9/13/2024, indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's care plan dated 9/14/2024 indicated Resident 29 was at risk for falls related to history of falls, The care plan goal indicated Resident 29 would have no falls with injury x (for) 90 days. The care plan interventions included reviewing past information on past falls, attempts to determine cause of falls, provide non-skid socks, place bed against the wall, assess for changes in mental status, pain status, mental status, and report to MD (medical doctor) as indicated, keep bed in low position, floor mat on the right side of the bed, non-skid floormats. (continued on next page)

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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 - Actual harm Residents Affected - Few	During a review of Resident 29 's Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated 12/24/2024, indicated Resident 29 's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making were severely impaired. The MDS also indicated Resident 29 required substantial/maximal assistance (the helper does more than half of the effort) with siting to lying, lying to sitting on the side of the bed, and dependent on toileting, chair/bed transferring, dressing, toileting, and personal hygiene. During a review of Resident 29 's Nursing documentation evaluation- admission, dated 9/13/2024, indicated Resident 29 was at high risk for falling. During a review of Resident 29's Change in Condition (COC) Evaluation form, dated 10/9/2024 indicated Resident 29 had a fall on 10/9/2024 at 11:12 AM but did not suffer any injuries. The form indicated that an Infection Prevention (IP) consultant saw the resident sitting in a wheelchair outside his room before the fall. The IP consultant reported that the resident fell forward onto the floor. Upon assessment, the resident was awake, responsive, and able to move both arms and legs without discomfort. A minor skin tear was found on the top of the right hand. Resident 29's family and doctor were informed, and the doctor ordered a transfer to the emergency room for further evaluation. During a Review of Resident 29's medical records showed that no Interdisciplinary Care Team (IDT) meeting was conducted after the fall on 10/9/2024. During a review of Resident 29's COC, dated 10/21/2024 indicated that Resident 29 had another fall that morning without any visible injuries. At 7:20 AM, a Certified Nursing Assistant (CNA) reported finding the resident on the floor. A Licensed Vocational Nurse (LVN) arrived and found the resident with his feet touching the wall and crouched near the bed with his head resting on it. The resident complained of back pain. The doctor was notified, and an X-ray was ordered at 8:00 AM. During a review of Resident 29's IDT meeting notes from 10/21/2024 at 10:28 AM, following the fall, indicated that safety measures would be put in place, including bed rails and a floor mat. The IDT also recommended a review of the resident's medications, continuation of the rehabilitation program, and the use of non-slip socks and a floor mat. During a review of Resident 29's COC Evaluation form dated 11/6/2024 indicated that the resident was found sleeping on a floor mattress and assisted back into bed. During a review of Resident 29 IDT dated 11/6/2024 timed at 12:01 AM, post fall incident on 11/16/24, indicated, the following will be provided to the resident: a Safety devices/Enabler, bed placed in low bed, floor pad/mat and nonskid socks. The IDT recommended continuing rehabilitation therapy five times per week, provide a hip protector, and update the resident's care plan to help prevent future falls. During a review of Resident 29's COC Evaluation form dated 11/27/2024 indicated that Resident 29 was moaning while walking and when his left ankle was moved. He was assisted back to bed, and no swelling was observed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the X-ray (a type of medical imaging that uses radiation to create pictures of the inside of your body, often used to see bones and diagnose broken bones or other injuries by showing how dense different tissues are within the body), dated 11/27/2024, at 1:45 PM, indicated Resident 29 had a non-displaced acute fracture of the left ankle. During a review of Resident 29's IDT meeting notes from 11/28/2024 indicated that the resident was experiencing pain in his left leg. The CNA reported that on 11/25/2024, just before lunchtime, the resident was found on the floor mat with both legs under the lower part of the bed. At that time, there was no noticeable change in his condition. The resident was assisted back into bed, and an additional mattress was placed next to the bed for safety. During a review of Resident 29 IDT dated 11/29/2024 at 9:59 post fall incident on 11/25/2024 indicated, Safety devices/Enabler in place: low bed, floor pad/mat and nonskid socks, bolters while on bed. IDT recommendations were to update the care plan updated to prevent reoccurrence. During a concurrent observation and interview on 2/25/2025 at 9:54 AM, Resident 29 was lying in bed, awake mumbling words and did not respond to questions appropriately. During an observation and interview on 2/26/2025 at 5:55 PM, with Family Member 1 (FM)1 in Resident 29's room. FM1 expressed concerns about Resident 29's care, stating that he has had multiple falls and that his floor mats are often not in place. During a concurrent interview and record review on 2/28/2025 at 10:46 AM with Licensed Vocational Nurse 5 (LVN) 5, Resident 29's COC was reviewed, LVN 5 stated that she was notified by a Physical Therapist that resident was complaining of pain during ambulation. LVN 5 stated that at the time she was unaware of any recent falls, she created a COC form to report about the resident's complaint of pain on 11/26/2024 and informed the doctor and FM 1. LVN 5 stated that the doctor ordered an x-ray of the left foot. She stated that results indicated the resident sustained a fracture. During a concurrent interview and record review on 2/28/2025 at 10:46 AM with LVN 5, Resident 29 care plan was reviewed. LVN 5 stated that facility did not update the resident's care plan after each fall as per policy and procedure. LVN 5 stated that the last update on the care plan was on 10/21/2024. LVN 5 stated that Resident 29 had multiple falls before the fracture occurred on 10/21/2024 and 11/6/2024 and did not complete required fall prevention measures. LVN 5 stated, The resident had a history of falls, but the care plan was not updated with new interventions before the resident sustained injury. The interventions implemented before the fall on 10/21/2024 included placing floor mats, providing non-slip socks, and physical therapy, but these measures should have been adjusted sooner. During a concurrent interview and record review of Resident 29 medical chart on 2/28/2025 at 10:46 AM with LVN 5, LVN 5 stated that after a fall it was required for the staffs to closely monitor the Resident 29 after a fall. LVN 5 stated after Resident 29 multiple falls resident was not closely monitored after the fall. LVN 5 stated that proper monitoring and supervision of Resident 29, the fall that led to the fracture could have been prevented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/28/2025 at 4:46 PM with Registered Nurse 1(RN) 1, RN 1 stated that Resident 29 was not properly assessed, monitored, and communicated to the staffs about the resident's risk for fall and that the resident was at high fall risk that led to preventable reoccurring falls and injury. RN 1 stated that the resident's care plan was not individualized or updated to reflect new interventions, and poor team communication further contributed to inadequate fall prevention measures. RN1 stated that there was no investigation for the root cause of the fall incidents on 10/9/2024, 11/6/2024 and 11/25/2024 and determine the appropriate intervention to implement to prevent recurrent falls. 36943 2. During a review of Resident 128's Admission Record, the facility admitted Resident 128 on 10/19/2023 with diagnoses including Type 2 Diabetes Mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), chronic (long-standing) kidney disease, presence of a right artificial shoulder joint, muscle weakness, and history of falling. During a review of Resident 128's Minimum Data Set ([MDS] a resident assessment tool), dated 11/2025/2024, the MDS indicated Resident 128 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember) The MDS indicated Resident 128 was independent with eating, oral hygiene, toileting, transferring from lying in bed to the side of the bed, transferring from sitting to standing, transferring from the chair/bed-to-chair, and walking 150 feet using a walker. During a review of Resident 128's physician orders, dated 12/5/2024, the physician orders indicated to apply Nystatin External Powder (medication to treat fungal or yeast infections of the skin) to axillae (underarms) topically(means applying a medication or treatment directly to the skin one time a day for prurigo nodularis (skin condition characterized by intense itching and the formation of small, firm modules on the skin) for 30 days. During a review of Resident 128's Change in Condition Evaluation (CICE), dated 12/23/2024 and signed by Registered Nurse 1 (RN 1) on 12/26/2024, the CICE indicated Resident 128 was found lying on the floor next to the bed. The CICE indicated Resident 128 slid off the bed, landed on the left shoulder, and complained of pain to the left elbow and left shoulder. The CICE indicated Resident 128's physician ordered for Resident 128 to transfer to the General Acute Care Hospital (GACH). During a review of Resident 128's GACH X-ray (image of the inside of the body) report, dated 12/23/2024, the X-ray report indicated Resident 128 had a left proximal (closer to the center of the body) humerus (shoulder bone) fracture. During a review of Resident 128's Census List (record of residents in the facility) the Census List indicated Resident 128 returned to the facility on [DATE]. During a review of Resident 128's History and Physical (H&P) Examination, dated 12/28/2024, the H&P indicated Resident 128 had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 128's IDT Care Conference, dated 12/30/2024, the IDT Care Conference indicated the IDT Care Conference did not include Resident 128 as an attendee. The IDT Care Conference indicated the root cause of Resident 128's fall was associated with the resident not asking for assistance as needed and poor balance. The IDT indicated Resident 128's care plan will be updated to prevent recurrence. During a review of Resident 128's care plan for an actual fall with (Specify: No Injury, Minor Injury, Serious Injury) Poor Balance, initiated 12/31/2024, the care plan goals and interventions were blank without any indication of goals and interventions. During a review of Resident 128's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation, dated 12/31/2024, the OT Evaluation indicated Resident 128 was seated at the edge of the bed, slipped while standing up, and fell on [DATE]. The OT Evaluation indicated Resident 128 was referred to OT due to a decline in the ability to move without pain, ability to perform activities of daily living ([ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), range of motion ([ROM] full movement potential of a joint [where two bones meet]), and strength. During a review of Resident 128's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 1/6/2025, the PT Evaluation indicated Resident 128 slipped on powder on the floor and fell on [DATE]. The PT Evaluation indicated Resident 128 was referred to PT due to the fall and was a fall risk, a decline in functional mobility, limitation with ambulation (the act of walking), and limited and painful movement. During a concurrent observation and interview on 2/27/2025 at 2:03 PM with Resident 128, Resident 128 was sitting on a bench located in the grass lawn next to the facility's parking lot. Resident 128 had a rollator walker next to bench (a mobility aid that features wheels, a frame, and handgrips, designed to assist individuals with walking difficulties by providing stability and balance) Resident 128 stated he slipped on powder, which was used for a body rash, on the floor, fell directly next to the bed, and broke the left arm approximately eight weeks ago. Resident 128 stated he already had a right shoulder replacement prior to living at the facility and stated the left arm did not feel the same after the shoulder fracture despite receiving therapy services. During a concurrent observation and interview on 2/28/2025 at 8:21 AM in Resident 128's room, Resident 128 was sitting at edge of the left side of the bed, facing the door. Resident 128 stated the facility staff had applied powder to Resident 128's body due to a skin rash during the time of the fall (on 12/23/2024). Resident 128 stated the powder was not visible on the floor but there were powder next to the bed. Resident 128 stated he stood up on the left side of the bed while reaching for the rollator walker, then he slipped on the powder, and he heard a crack upon falling onto the left arm. Resident 128 stated the floor was slippery to begin which became more slippery with the powder present on the floor. During an observation the floor on the left side of Resident 128's bedside was observed dry, but the surface was slippery. Resident 128's shoes slid slightly forward when Resident 128 attempted to plant both feet on the floor. During an interview with Resident 128, Certified Nursing Assistant 1 (CNA 1) walked into the room and stated she felt the floor on Resident 128's bedside was dry but felt slippery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the same interview on 2/28/2025 at 8:21 AM in Resident 128's room, Resident 128 stated he pushed the call light after the fall, but nobody came for at least 10 minutes. Resident 128 stated he managed to kick the bedside table over, causing CNA 11 (no longer an employee) to come into the room and then called RN 1 for assistance. Resident 128 stated RN 1 came into the room after the fall and called the ambulance, which took Resident 128 to the hospital. During a concurrent interview and record review on 2/28/2025 at 12:07 PM with RN 1, RN 1 reviewed Resident 128's care plan for actual fall, initiated 12/31/2024 (after the IDT Care Conference), and stated Resident 128's care plan did not include any interventions to prevent recurrent fall that addressed preventing the resident from slipping on the floor due to the Nystatin powder. During an interview on 2/28/2024 at 12:44 PM with Resident 128 in the presence of RN 1, Resident 128 stated he slipped on powder located on the floor and could not prevent himself from falling (on 12/23/2024). Resident 128 stated the facility did not meet with Resident 128 after the fall. During a concurrent interview and record review on 2/28/2025 at 12:46 PM with RN 1, RN 1 reviewed Resident 128's MDS, dated [DATE], physician orders, dated 12/5/2024, and IDT Care Conference, dated 12/30/2024. RN 1 stated the MDS indicated Resident 128 was independent with transferring from lying in bed to the side of the bed, transferring from sitting to standing, transferring from the chair/bed-to-chair, and walking 150 feet using a walker. RN 1 stated Resident 128 did have physician orders to apply Nystatin powder at the time of the fall. RN 1 stated the IDT Care Conference indicated the root cause of Resident 128's fall was poor balance and not asking for assistance as needed. RN 1 stated the root cause was not accurate since Resident 128 was independent with sit to stand transfers and walking at the time of the fall and would not need to call for assistance. RN 1 stated the facility should have included Resident 128 in the IDT Care Conference and would have discovered the root cause was the presence of Nystatin powder on the floor. RN 1 stated the IDT should have developed interventions with Resident 128 to prevent further falls. 50203 3. During a review of Resident 491's Admission Record, indicated Resident 491 was admitted on [DATE] with diagnoses which included acute respiratory failure (ARF, when the lungs have trouble getting enough oxygen [odorless gas needed for plant and animal life] into the blood) with hypoxia (condition where the body's tissues doesn't have enough oxygen), unspecified atrial fibrillation (a heart condition that caused an irregular heart beat), and other abnormalities of gait (the pattern a person walks) and mobility. During a review of Resident 491's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 2/15/2025, indicated Resident 491 does have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 491's Minimum Data Set (MDS, a federally mandated resident assessment), dated 2/20/2025, indicated Resident 491's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was severely impaired. The MDS indicated Resident 491 required moderate assistance (helper does less than half the effort) when transferring from sitting to lying in bed, lying to sitting on the side of the bed and the ability to sit to stand from the chair. The MDS indicated Resident 491 was frequently incontinent (involuntary loss of bladder or bowel control) of urine and stool. The MDS indicated Resident 491 did not have any history of falls prior to admission to the facility. During a review of Resident 491's care plan, dated 2/15/2025, the care plan indicated Resident 491 was at risk for falls related to confusion, gait (the way the residents walks or moves /balance problems. The care plan goals indicated the resident will be free of falls by 5/16/2025. The care plan interventions included anticipating and meeting the residents needs and ensuring the resident's call light was within reach. During a review of Resident 491's Nursing Documentation Evaluation document, dated 2/15/2025, the document indicated Resident 491's had a risk factor of falls related to disorientation and confusion. During a review of Resident 491's Change in Condition Evaluation (CoC, a form used to document and report a significant change in a resident's health or circumstances) document, dated 2/18/2025 timed at 3:40 PM, LVN 5 indicated Resident 491 had episodes of confusion and was found crawling on the floor. During a review of Resident 491's care plan, dated 2/18/2025, the care plan indicated Resident 491 was at risk for falls due to episodes of confusion and crawling on the floor. The care plans goals indicated the resident will have no falls by 5/16/2025. The care plans interventions, included providing verbal safety reminders, placing the call light within reach, and monitoring for and assisting Resident 491 with toileting needs. During a review of Resident 491's Nursing Progress Notes, dated 2/19/2025, Licensed Vocational Nurse (LVN) 11 indicated at 3:30PM on 2/19/2025, Resident 491 was crawling on the floor. LVN 11 indicated one to one staffing was provided. During an observation on 2/26/2025 at 9:40 AM in the hallway by Resident 491's room, Resident 491 was raising his voice in foreign language asking for food as Certified Nurse Assistant (CNA) 10 was seen walking out of Resident 491 and saying to Resident 491 Let me change you. Resident 491 continued to refuse CNA 10's assistance and was asking for food. CNA 10 walked out of Resident 491's room, and Treatment Nurse (TXN) 1 asked CNA 10 to check another resident's room. CNA 10 walked away from Resident 491's room. Resident 491 could be heard raising his voice asking for help. During an observation on 2/26/2025 at 9:42 AM in Resident 491's room, Resident 491 was found lying on his left side on the floor by the foot of the bed on the right side of the bed. Resident 491 was without clothing covered with blanket and lying on a bedsheet stained with stool. Resident 491 was heard raising his voice speaking in a foreign language asking for help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/26/2025 at 9:53AM with CNA 10, CNA 10 stated, she went into Resident 491's room to assist the resident with the morning care, and Resident 491 refused his linens and adult briefs to be changed. CNA 10 stated, someone (unable to identify) told her to go change another resident's linens. CNA 10 stated, she stepped out of Resident 491's room to go change another resident's linen while Resident 491 was still lying in bed. CNA 10 did not state the reason why Resident 491 was refusing to have his linens and adult brief to be changed. During an interview on 2/26/2025 at 9:53AM with CNA 10, CNA 10 stated, she was unaware Resident 491 was at risk for fall. CNA 10 stated, nobody told me. I should not have left (Resident 491) alone. CNA 10 stated, she was unaware Resident 491 needed frequent supervision, and she was not aware how the resident fell on the floor because the resident was left on the bed when she left the room to assist another resident. During an interview on 2/27/2025 at 5:36PM with CNA 12, CNA 12 stated, Resident 491 has tried to get out of bed a couple times before because he was always trying to stand up. CNA 12 stated, Resident 491 was mad because he wants to walk but he cannot. CNA 12 stated, Whenever I work with him, I end up trying to catch him. CNA 12 stated, Resident 491's room was located far away from the nursing station. CNA 12 stated, I make sure to be aware of him at all times by passing by his room and checking if he needs any assistance. CNA 12 stated, she tried to stay close to Resident 491 when she was assigned to him because Resident 491 was always trying to get up. During an interview on 2/28/2025 at 3PM with LVN 10, LVN 10 stated, Resident 491 was considered a fall risk. LVN 10 stated, Resident 491 has a yellow star outside his door, which indicated Resident 491 was a fall risk. LVN 10 stated, Resident 491 needed frequent monitoring and supervision because Resident 491 has a history of putting himself on the floor. During a concurrent record review and interview on 2/28/2025 at 5:38PM with RN 1, Resident 491's Nursing Documentation Evaluation, dated 2/15/2025 and CoC, dated 2/18/2025 were reviewed. The Nursing Documentation Evaluation, dated 2/15/2025, indicated Resident 491 was a fall risk. Resident 491's CoC, dated 2/18/2025, indicated Resident 491 was found crawling on the floor. RN 1 stated, Resident 491's fall risk indicators indicated he was disorientated and confused. RN stated, Resident 491 had a history of being found on the floor and crawling three different episodes since his admission on 2/15/2025. RN 1 stated, Resident 491 required more frequent staff supervision and a re-evaluation of fall precaution interventions because Resident 491 had a history of being found on the floor on 2/18/2025, 2/19/2025, and 2/26/2025. During a review of the facility policy and procedure (P&P) titled, Fall Management, effective on 5/26/2021, the P&P's purpose included to reduce risk for falls and minimize he actual occurrence of falls. The P&P indicated residents experiencing a fall will receive appropriate care and investigation of the cause. The P&P also indicated the IDT reviewed the incidence after the fall and updated the care plan to reflect new interventions if a resident falls in the facility. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention and Management, effective date 5/26/2021, indicated: 1. Residents at risk for falls as part of the nursing process. 2. Document accident/incident in the clinical record (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Residents determined to be at risk will receive appropriate intervention to reduce risk and minimize injury. 4. Communicate resident's fall risk to the caregivers. 5. Develop individualized plan of care and review and revise as indicate. 6. Update care plan to reflect new interventions. 7. Interdisciplinary to review post Fall.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to provide care and services to prevent new and recurrent urinary tract infection (UTI an infection in any part of the urinary system, the kidneys, bladder, or urethra)) infection, blockage (an obstruction or flow which makes movement or flow difficult or impossible) or bleeding for five of five sampled residents Resident 180,10, 57, 14 and 25) by failing to: 1. Ensure no delay in informing Resident 180's primary physician of Resident 180's critical lab values of white blood cell count (WBC, a type of blood cell that helps fight infection and disease) and low blood glucose (BG, the main sugar found in the blood), which were reported by the laboratory on 2/23/2025 at 11:48 PM as evidenced by the critical lab results were followed up on 2/24/2025 at 2:36 PM (approximately 14.5 hours when the critical lab results were reported). 2. Ensure the Licensed Nurses assessed and documented their daily nursing assessment related to Resident 180's indwelling catheter (a tube inserted into the bladder to drain urine) and urine output characteristics from 2/15/2025 to 2/25/2025. 3. Ensure the Licensed Nurses continued to monitor, document the vital signs, (measurements of the body's most basic functions, such as breathing rate, BP, HR, and temperature),change in mental status and food intake from 2/24/2025 to 2/25/2025 when Resident 180 started to become more lethargic (weak), responsive only to sternal rub (rubbing the middle of the chest to elicit pain and response) and immediately called the physician for the resident's worsening change in condition. 4. Ensure Residents 10 and 57 with suprapubic catheter (a device surgically inserted into the bladder to empty urine from the bladder) and history of recurrent UTIs were kept and dry when incontinent (no control) of urine and stool. 5. Ensure Residents 14 with indwelling urinary catheter and 25 suprapubic catheters, the facility failed was assessed and monitored the signs and symptoms of UTI such the presence sediment (presence of crystals, bacteria, or blood exit through the urine in the urine, blood in the urine, back/flank pain with urination and fever as ordered by the physician. As a result of these deficiencies Resident 180 was transferred to General Acute Care Hospital (GACH) 1 and arrived at the Emergency Department (ED) by ambulance on 2/25/2025 at 3:19 PM with admitting blood pressure (BP, the measurement of the pressure or force of blood inside the blood vessels) 64/44 mm Hg (Millimeters of mercury, a unit of measurement for pressure), and heart rate (HR) of 115 per minute (unit of time). Subsequently, Resident 180 was admitted to the Intensive Care Unit (ICU, a hospital ward that provides specialized care for patients who are very ill or injured) where the resident was diagnosed with septic shock (a life-threatening condition that occurs when an infection causes dangerously low BP and organ failure) with obstructive uropathy (a condition in which the flow of urine is blocked). While in the ICU, 700 milliliters (unit of volume) of purulent urine (urine that contains pus, a thick, yellowish fluid which indicates a sign of infection) was drained out from the indwelling catheter (a tube inserted into the bladder to drain urine). (continued on next page)

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	056487	A. Building B. Wing	03/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	In addition, for Residents 10, 14, 57 and 25 the residents were at risk for recurrent UTIs that could lead to pain and hospitalization and decline in the wellbeing. Findings: 1. During a review of Resident 180's Admission Record (AR), the AR indicated the facility admitted Resident 180 on 1/29/2025 with diagnoses that included pneumonia (a severe an infection of the lungs that may be caused by bacteria, viruses, or fungi), sepsis (a life threatening infection in the blood which could lead to decreased in BP, increased HR, shortness of breath and altered level of consciousness, that can damage the body organs). During a review of Resident 180's Minimal Data Set (MDS-a federally mandated resident assessment), dated 2/4/2025, indicated Resident 180's cognition (ability to think, remember, and reason with no difficulty) was intact and needed partial assistance (helper does less than half the effort) in eating and personal hygiene. During a review of Resident 180's Plan of Care Progress Notes for Physical Medicine and Rehabilitation, dated 2/4/2025, indicated Resident 180 was identified to have diagnoses and/or comorbidities which were impacting functional status. The notes indicated the diagnoses included sepsis, with a high risk of complication. The notes indicated Resident 180's multiple medical issues necessitate frequent clinical evaluations, placing him at high risk for readmission without proper care. Neglecting regular monitoring and management may result in symptom exacerbation and complications, possibly requiring hospitalization . The notes indicated Resident 180 would require close monitoring for altered mental status, fever and or leukocytosis (an abnormally high number of white blood cells in the bloodstream) that would indicate recurrent or worsening state of sepsis. During a review of Resident 180's Order Summary Report (OSR), indicated on 2/5/2025, Resident 180 had a physician order for Indwelling Catheter for BPH [Benign Prostatic Hyperplasia, a benign (not cancer) condition in which the prostate gland (a gland in the male reproductive system) is larger than normal] and obstructive uropathy. The order indicated to change the indwelling catheter for blockage, leaking, pulled out, excessive sedimentation; change catheter drainage bag as needed and with every change of indwelling catheter. Further review of Resident 180's OSR lacked orders or other documentation for catheter care. During a review of Resident 180's care plans, indicated that facility staff failed to develop a care plan for interventions and monitoring of Resident 180's indwelling catheter use. During a review of Resident 180's Daily Documentation [Nursing assessment on overall health of the resident including vital signs (measurements of the body's most basic functions, such as breathing rate, BP, HR, and temperature), mental status, and activity of daily living], dated 2/14/2025, indicated Resident 180 was alert and oriented to time, place, and person. The assessment indicated Resident 180's indwelling catheter was in place with yellow urine output. During a review of Resident 180's Daily Documentation for the month of February 2025, indicated that facility staff failed to complete daily nursing assessments from 2/15/2025 to 2/25/2025 related to indwelling catheter and urine output characteristics. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 180's Order Summary Report (OSR), indicated on 2/15/2025 (10 days after the physician order indwelling catheter on 2/5/2025), Resident 180 had a physician order for indwelling catheter care every shift. The order failed to specify how facility staff were to care for the indwelling catheter. During a review of Resident 180's Treatment Administration Record (TAR) for the month of February 2025, the TAR indicated Resident 180 was given indwelling catheter care as ordered from 2/15/2025 to 2/25/2025. The TAR did not specify how the care was given and if the characteristic of the urine was assessed. During a review of Resident 180's phone orders, dated 2/22/2025, indicated Resident 180 had a physician order on 2/22/2025 at 7:39 PM for CBC (complete blood count, a blood test that measures the number and size of different types of blood cells), CMP (a routine blood test that measures 14 different substances in a sample of the blood), and UA with C&S (urinalysis with culture and sensitivity). During a review of Resident 180's Laboratory Results Report, dated 2/23/2025 timed at 11:48 PM, indicated Resident 180 had critical lab values for BG level of 60 milligrams (unit of weight) per deciliter (a metric unit of capacity) (mg/dL- reference range 65-99 mg/dL) and WBC count of 39.59 cells per microliter (unit of volume) of blood (normal reference range was 4-11 cells per microliter of blood). During a review of Resident 180's Change in Condition (CIC) Evaluation, dated 2/24/2025, indicated Resident 180 had critical lab results with low BG of 60, high WBC of 39.59 with no fever, clear breath sounds, and vital signs within normal range. The CIC indicated, on 2/24/2025 at 2:48 AM, LVN 5 notified Resident 180's Nurse Practitioner (NP) 1 about critical lab results of low blood glucose and high WBC and received a physician order for antibiotics (medication given to treat infection), however, further review of the CIC indicated that facility staff failed to document the antibiotic order. During a review of Resident 180's care plans since admitted [DATE], indicated a care plan was not developed to indicate interventions and monitoring of Resident 180 with critical lab results of low BG and high WBC on 2/23/2025. During a review of Resident 180's Follow-up Documentation for the CIC of critical lab results of low BG and high WBC, dated 2/24/2025, timed at 2:36 PM, the document indicated Licensed Vocational Nurse (LVN) 10 followed up with NP 1 for abnormal labs with no new order and to continue to monitor Resident 180. During a review of Resident 180's phone orders, dated 2/25/2025, Resident 180 had a physician order on 2/25/2025 at 10:14 AM for Zosyn (medication to treat infection) intravenously (into the vein/bloodstream) three times a day for Leukocytosis for 10 Days. During an observation on 2/25/2025 at 10:05 AM in Resident 180's room, Resident 180 was lying with a towel on his head and eyes closed. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 10:07 AM with Resident 180's Family Member (FAM) 1, FAM 1 was shaking Resident 180's arms then both legs and was calling Resident 180 to wake up, Resident 180 did not respond, and his eyes remained closed. FAM 1 stated, Resident 180 always called him every day, but on 2/24/2025, Resident 180 did not call him on the phone. FAM 1 stated, Resident 180 had not eaten anything since 2/24/2025 morning. During a concurrent observation and interview on 2/25/2025 at 11:05 AM with Certified Nurse Assistant (CNA) 4 in Resident 180's room with the presence of FAM 1, Resident 180 was lying in bed with his eyes closed. CNA 4 stated, she needed to change Resident 180 because he was wet due to his indwelling catheter was leaking. While CNA 4 was cleaning Resident 180, the resident was observed with an indwelling catheter and a sheet wet with urine. Resident 180 did not wake up while being changed. During a review of the facility's Charting Guidelines, indicated Resident 180 was to be monitored from 2/24/2025 to 2/27/2025 for vital signs, pain, change in behavior, level of consciousness and mental status due to abnormal labs, and generalized weakness. During a review of Resident 180's Weight and Vitals Summary, there was no documented evidence that Resident 180's BP, HR, oxygen saturation level, body temperature and level of consciousness were monitored from 2/24/2025 at 2:36 PM to 2/25/2025 at 1:54 PM (approximately for 24 hours, the resident's vital signs were not assessed). During a review of Resident 180's CIC Evaluation, dated 2/25/2025, indicated Resident 180 was noted with no intake for breakfast and lunch, vomiting, and overall weakness. The CIC indicated NP 1 was made aware of the resident's worsen condition at 1:30 PM on 2/25/2025. The CIC indicated NP 1 recommended to transfer Resident 180 to GACH for further evaluation. The CIC indicated Resident 180's BP was at 90/62 with HR of 110 at 1:54 PM on 2/25/2025. During a review of Resident 180's Order Summary Report (OSR), indicated on 2/25/2025, NP 1 ordered Resident 180 to transfer to acute hospital for further evaluation. During a concurrent record review and interview on 2/25/2025 at 1:05 PM with LVN 5, Resident 180's CIC Evaluation, dated 2/24/2025, timed at 3:31 AM was reviewed. LVN 5 stated, she worked as a Desk Nurse during the day, who was responsible to assist the Charge Nurses in communicating with the doctors. LVN 5 stated, she only worked dayshift and was not working at nighttime on 2/23/2025 and 2/24/2025. LVN 5 stated, in the morning of 2/25/2025, she noticed that there was an incomplete CIC which was created on 2/24/2025 at 3:31 AM for critical lab results of low glucose and high WBC. LVN 5 stated, the CIC indicated that on 2/24/2025 at 2:48 AM, Resident 180's physician was messaged and was still waiting for response, so she called Resident 180's covering physician (NP 1) to report the critical lab results and received a physician order for antibiotics around 9:30 AM. LVN 5 stated, on 2/25/2025, after she received order for antibiotics, she revised the physician recommendations on 2/24/2025 at 2:48 AM from waiting for response to NP 1 made aware with new orders for IV antibiotic. LVN 5 stated, she forgot to change the physician notification time from 2/24/2025 at 2:48 AM to 2/25/2025 at 9:30 AM. LVN 5 stated, she should have documented her physician notification in Resident 180's progress notes or a follow up assessment for the CIC. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/25/2025 at 1:13 PM with LVN 7, LVN 7 stated, she was taking care of Resident 180 from 11 PM on 2/24/2025 until 7 AM on 2/25/2025. LVN 7 stated, did not receive any report from LVN 9 (3-11 PM shift LVN) that Resident 180 was to be monitored for critical lab results. LVN 7 stated during the shift from 11 PM on 2/24/2025 until 7 AM on 2/25/2025, Resident 180 was observed asleep throughout the shift, and she did not check or ensure Resident 180's vital signs were taken during night shift when she took care of Resident 180. During an interview on 2/25/2025 at 1:17 PM with LVN 8, LVN 8 stated, he was the charge nurse for Resident 180 since 7 AM on 2/25/2025. LVN 8 stated, he was not aware and did not receive any report from previous nurse on the night shift (LVN 7) that Resident 180 was to be monitored for critical lab results of low blood glucose, high WBC, and generalized weakness. LVN 8 stated, he took care of Resident 180 for the first time today (2/25/2025), he did not know that Resident 180's baseline mental status as more awake and alert before, so he did not notify the physician. LVN 8 stated, Resident 180 was asleep during his shift on 2/25/2025 prior to transfer to GACH 1. During an interview on 2/25/2025 at 3:40 PM with LVN 9, LVN 9 stated, she was the Charge Nurse who took care of Resident 180 from 3-11 PM on 2/23/2025 and 2/24/2025. LVN 9 stated, she saw a significant change in Resident 180's mental status. LVN 9 stated, on 2/23/2025, Resident 180 was awake, alert, and able to eat, but on 2/24/2025, during 3-11 PM shift, Resident 180 was lethargic, sleeping, did not respond when spoken to, and did not eat his dinner. LVN 9 stated, she did not notify the Resident 180's physician because she was informed by LVN 10 (7-3 PM LVN on 2/24/2025) that the physician was already aware of the situation with no new order but to continue to monitor the resident. During a review of Resident 180's GACH 1's ED (Emergency Department) Triage, dated 2/25/2025, indicated Resident 180 arrived at the ED by ambulance on 2/25/2025 at 3:19 PM with admitting BP of 64/44 mm Hg, and HR of 115 per minute. During a review of Resident 180's GACH 1's History and Physical (H&P) Notes, dated 2/25/2025, timed at 7:15 PM, indicated Resident 180 was admitted to GACH 1 with altered mental status and drowsiness. The H&P indicated Resident 180's CT (computed tomography, scan is a non-invasive medical imaging procedure that uses X-rays to create detailed pictures of the inside of the body) of abdomen/pelvis revealed distended bladder. The physician's assessment indicated Resident 180 had septic shock with obstructive uropathy. The H&P indicated Resident 180 had an indwelling catheter and purulent urine was drained out from the bladder with 700 milliliter was removed. During a review of Resident 180's GACH 1's Progress Notes-Nursing, dated 2/25/2025, timed at 11:56 PM, indicated Resident 180 was admitted to GACH 1's ICU at 10:30 PM with an indwelling mixed of pus and blood output. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 2/26/2025 at 5:23 PM with Resident 180's FAM 1, FAM 1 stated, on 2/24/2025, he brought food to Resident 180 around noon time but Resident 180 was sleeping so after waiting for an hour, FAM 1 left his food at the bedside and left the facility. FAM 1 stated, he came back to the facility around 6 PM on the same day, he tried to touch and shake Resident 180 to wake him up but Resident 180 would not wake up, so he notified LVN 9. FAM 1 stated, LVN 9 and Registered Nurse (RN) 2 came to comfort him and told him that Resident 180's BP was low, and that Resident 180 was running a fever, so they had a towel over Residents 180's head. FAM 1 stated, RN 2 and LVN 9 told him that they would monitor Resident 180 but did not explain to him how they would monitor Resident 180. FAM 1 stated, he thought Resident 180 was already dead. FAM 1 stated, he stayed for 2.5 hours and did not see any staff come back to check the resident's vital signs. During an interview on 2/27/2025 at 4:20 PM with NP 1, NP 1 stated, on 2/20/2025 he ordered laboratory tests for blood and urinary analysis (a series of test on the urine) for a general checkup to make sure Resident 180 was stable with no infection related to his Foley catheter, in preparation for discharging Resident 180 home with his family. NP 1 stated, he did not receive any call or messages from the nurses regarding Resident 180's condition from the facility before he ended his shift at 7 PM on 2/24/2025. NP 1 stated, he only received text messages from the nurses reporting that Resident 180's HR was fast and was running a fever, so he ordered to monitor the resident. NP 1 stated, monitor means frequent assessment during each shift for change in mental status, abnormal vital signs, any decrease in baseline condition and that he expected the LVNs to report their findings to the physician. NP 1 stated, if he was aware of the lab results and the mental status changes when Resident 180 was not responsive and not eating on the night of 2/24/2025, he would have recommended to transfer Resident 180 to an acute hospital because, NP 1 stated, it was a 9/10 urosepsis [a life-threatening condition that occurs when a urinary tract infection (a bacterial infection that occurs in the urinary tract) spreads to the kidneys and causes sepsis], and for BG at 60, the BG should also be monitored as well as sign and symptoms of hypoglycemia. During an interview on 2/27/2025 at 5:12 PM with LVN 10, LVN 10 stated, he took care of Resident 180 from 7 AM to 3 PM on 2/24/2025. LVN 10 stated during the first or second hour of his shift, the RN supervisor gave him lab results and asked him to wait for the physician to respond so he did not call NP 1 in the morning of 2/24/2025. LVN 10 stated, Resident 180 was alert and responded to verbal command at the start of his shift. LVN 10 stated, around 2 PM, Resident 180 was slightly lethargic with generalized weakness, and elevated temperature so he notified NP 1 and received order to monitor. During an interview on 2/28/2025 at 10:30 AM with LVN 5 (Desk Nurse), LVN 5 stated, she was helping on 2/25/2025. LVN 5 stated, around 1:15 PM, when she came in Resident 180's room to notify Resident 180's FAM 1 that Resident 180 had a physician order for antibiotics, FAM 1 told her that Resident 180 had not eaten anything since 2/24/2025. LVN 5 stated, LVN 5 asked CNA 4 and was informed that Resident 180 did not have breakfast and lunch. LVN 5 stated, she notified NP 1 and received an order around 2 PM to transfer Resident 180 to an acute hospital for further evaluation. LVN 5 stated, LVN 8 was responsible to monitor, assess, and follow up with the physician when Resident 180 continued to not able to eat breakfast and drowsy. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview on 2/28/2025 at 10:45 AM with LVN 5, Resident 180's Daily Documentation, for the month of February 2025, were reviewed. LVN 5 stated, per facility's protocol, the dayshift LVNs were responsible for Resident 180's assessment and document them daily. LVN 5 stated, based on the record, there was no daily assessment since 2/14/2025, which indicated Resident 180 was alert and oriented to time, place, and person. During a concurrent record review and interview on 2/28/2025 at 11:15 AM with LVN 10, Nursing Station 1's CIC book with Charting Guidelines, for the month of February 2025, was reviewed. LVN 10 stated, when a resident had any CIC, the LVN who created the CIC was responsible to list the resident's name, reason for CIC, with the start date and end date to monitor the resident. LVN 10 stated, Resident 180 was listed on 2/24/2025 with abnormal labs, generalized weakness and to be monitored for all shifts from 2/24/2025 to 2/27/2025. LVN 10 stated, the Charting Guidelines indicated Resident 180 to be monitored for vital sings, pain, change in behavior, level of consciousness and mental status. There no documented evidence the Resident 180 was monitored for the change in vital signs, pain, change in behavior and change in level of consciousness. During an interview on 2/28/2025 at 12:30 PM with CNA 4, CNA 4 stated, she took care of Resident 180 from 7AM to 3 PM on 2/24/2025 and 2/25/2025. CNA 4 stated, on 2/24/2025, Resident 180 ate very little of his breakfast, and was not able to eat anything for lunch. CNA 4 stated, around 1-2 PM on 2/24/2025 she tried to wake Resident 180, but he would not respond and was very drowsy. CNA 4 stated, she reported Resident 180's condition to LVN 10 and was told by LVN 10 that the doctor was already aware and to continue to monitor Resident 180. CNA 4 stated, when she started her shift on 2/25/2025 at 7 AM, Resident 180 was very drowsy with a towel over his head. CNA 4 stated, Resident 180 did not eat breakfast and did not wake up when she tried to wake Resident 180 up for at least 2 times prior to his transfer to GACH 1. CNA 4 stated, Resident 180 had an indwelling catheter, but Resident 180 was frequently wet with urine. During an interview on 2/28/2025 at 4:44 PM with the Acting Director of Nursing (ADON), the ADON stated, critical lab results must be reported to the physician promptly to avoid delay in treatment and Resident 180 was supposed to be monitored for his mental status, vital signs for at least 72 hours. The ADON stated, all shift LVNs were responsible to monitor and document their findings in the Progress notes or the CIC-Follow up assessment so the LVNs could see the changes in Resident 180's condition to report to the physician. The ADON stated, if Resident 180 was awake and alert on 2/23/2025 but was lethargic, responding only to sternal rub with poor intake, she expected RN 2 and LVN 9 to immediately notify Resident 180's physician for a transfer out for higher level of care. ADON stated, LVN 8 was supposed to follow up with the physician right away when Resident 180 continued to be drowsy and not able to eat breakfast, not waiting until after lunch time. The ADON stated, a delay in physician notification could result in a delay in care and worsen resident's condition. During an interview on 2/28/2025 at 5:40 PM with CNA 5, CNA 5 stated, she took care of Resident 180 from 3-11 PM on 2/24/2025. CNA 5 stated, Resident 180 was very drowsy and would not wake up and did not have dinner. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/28/2025 at 7:15 PM with RN 2, RN 2 stated, he was in charge of Resident 180's care from 3-11 PM on 2/24/2025. RN 2 stated, he received report from the previous shift that Resident 180 was under monitoring for critical labs and lethargy. RN 2 stated, toward the nighttime, he heard crying sounds from Resident 180's FAM 1 with concern for Resident 180's lethargy, unresponsiveness, and not able to eat anything. RN 2 stated, Resident 180 would not respond to voice or touch, and would only respond to sternal rub (rubbing the mid chest to elicit a response). RN 2 stated, he did not call Resident 180's physician about what he observed on Resident 180's condition because he was informed by LVN 9 that a CIC was already created and that LVN 9 would monitor Resident 180. During a review of the facility's Policy and Procedure (P&P) titled, Urinary Tract Infections/Bacteriuria-Clinical Protocol, revised 2018, indicated: -The physician and staff will identify individuals with history of symptomatic UTIs, (such as noticeable symptoms like pain or burning during urination, strong urge to urinate, cloudy or bloody urine, etc.) and those who have risk factors (for example, an indwelling catheter, urinary outflow obstruction) for UTIs. -The staff and practitioner will identify individuals with possible signs and symptoms of a UTI, nurses should observe, document and report signs and symptoms in detail. During a review of the facility's P&P titled, Change in Condition: Notification of, dated 8/25/2021, indicated Facility must immediately inform the resident, consult with the Resident's physician and/or NP, and notify, consistent with his/her authority, Resident Representative where there is a significant change in the resident's physical, mental, or psychosocial status (such as a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). During a review of the facility's P&P titled, Guidelines for Charting and Documentations, revised 2012, indicated the purpose of charting and documentation is to provide: a. A complete account of the resident's care, treatment, response to care, signs, symptoms, etc., and the progress of the resident's care. b. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. c. Nursing service personnel with a record of the physical and mental status of the resident. -Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observation. -For Medicare residents: chart daily, all three shifts must chart (e.g., vital signs, eating, condition of the resident, etc.) -Document assessments, interventions, treatments, outcomes, etc. 50012 (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	2. During a review of Resident 10's Admission Record, the facility admitted Resident 10 on 3/20/2018 and readmitted on [DATE] with diagnoses including UTI, and muscle weakness. During a review of Resident 10's History and Physical (H&P), dated 1/15/2025 indicated, Resident 10 did not have the mental capacity to make medical decisions. During a review of Resident 10's MDS, dated [DATE], indicated the cognitive skills for daily decisions making of the resident was severely impaired, and the resident was dependent on staff for toileting hygiene, that required supervision to extensive assistance from the staff for the activities of daily living. The MDS indicated Resident 10 was frequently incontinent of bladder and bowel. During a review of Resident 10's Change in Condition (COC) Evaluation form, dated 5/22/2024 indicated Resident 10 had pain when urinating on 5/22/2024 and MD (Medical doctor) notified. During a review of Resident 10's urinalysis (UA- checking the appearance, concentration and content of urine) results dated 5/27/2024, indicated Resident 10's urine appearance was cloudy, with presence of white blood cell (WBC), small bacteria, and few mucus threads (thin, stringy particles that can be visible in the urine), and Klebsiella pneumonia in the urine (a bacterium commonly found in the intestines of humans and other animals, where it usually causes no harm. If entering the urinary system, this can cause UTI). During a review of Resident 10's COC Evaluation form, dated 8/13/2024 indicated Resident 10 had burning (sensation) with urination on 8/13/2024 and the MD was notified and ordered UA. During a review of Resident 10's UA results dated 8/19/2024, indicated Resident 10's urine appearance was cloudy, with presence of WBC, small bacteria, and few mucus threads, and with Escherichia coli in the urine (E. coli, a bacterium commonly found in the intestines of humans and other animals that can cause UTI). During a review of Resident 10's COC Evaluation form, dated 1/3/2025 indicated Resident 10 had a change of condition resulting in the left side weakness, slurred speech (difficult to speak clearly), and elevated blood pressure and was transferred to the hospital. During a review of Resident 10's GACH Progress Note dated 1/3/2025, indicated the Resident 10 had severe sepsis (infection in the blood) likely secondary to UTI. During a review of Resident 10's GACH medication administration dated 1/3/2025, indicated the Resident 10 received Meropenem (medication use to treat infection)1000mg (milligram) every 12 hours for UTI. During an observation on 2/26/2026 at 12:32 PM, in Resident 10's room, Resident 10 was observed sitting in a wheelchair. During an interview on 2/26/205 at 6:45 PM with Family Member 2(FM) 2, FM 2 stated, she has found Resident 10 soiled or wet when she visits Resident 10 and was concern that Resident 10 has had recurrent UTIs while at the facility. FM 2 stated that Resident 10 was transferred to the hospital in January 2025 due to UTI. (continued on next page)

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	056487	A. Building B. Wing	03/01/2025

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 0690 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview conducted on 2/28/2025 at 1:45 PM with Certified Nurse Assistant (CNA)13, indicated the Documentation Survey Reports Personal Hygiene: toileting Resident 10 was dependent on staff for incontinence care and brief changes. CNA 13 stated that residents who are incontinent required to be checked at least every two hours or as needed. CNA 13 stated due to staffing shortages, Resident 10 was sometimes left in a wet or soiled diaper for longer periods. CNA 13 stated that documentation of incontinence care was sometimes incomplete, making it unclear whether the resident received timely incontinent care. CNA 13 stated that prolonged exposure to urine and stool can cause bacterial growth and increase the risk of UTIs. During a concurrent interview and record review on 2/28/2025 at 2:45 PM with the Registered Nurse 1 (RN) 1, Resident 10's care plans were reviewed. RN1 stated there were no care plan to monitor or prevent the reoccurrence of UTIs for Resident 10. RN1 stated that Resident 10 had multiple UTIs this last one requiring hospitalization but stated that no additional infection prevention measures were implemented beyond routine care. RN 1 stated that with appropriate care and monitoring Resident 10 should not have had recurrent UTIs. 3. During a review of Resident 57 's Admission Record (Face Sheet), the facility admitted Resident 57 on 1/17/2018 and readmitted on [DATE] with diagnoses including UTIs an infection in any and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 57's History and Physical (H&P), dated 9/25/2024 indicated, Resident 57 did not have the mental capacity to make medical decisions. During a review of Resident 57's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/31/2025, indicated the cognitive (the ability to think and process information) severely impaired and was totally dependent on two persons for bed mobility, transfer, dressing, eating, and toileting. The MDS indicated the resident had an indwelling catheter and was incontinent of bowel. During a review of Resident 57's COC Evaluation form, dated 9/14/2024 indicated Resident 57 had hematuria (presence of blood in the urine) on 9/14/2024 MD notified and ordered GAGH transfer. During a review of Resident 57's GACH record indicated a UA obtained on 9/19/2024, result was Resident 57's urine appearance was turbid (unclear and murky appearance), had the presence of white blood cell, bacteria. UA also indicated Staphylococcus SPP in the urine (a bacteria commonly found in the in humans' skin, nose, mouth, lungs, and stomach if entering the urinary system, this can cause UTI). During a review of Resident 57's GACH History and Physical dated 9/19/2024, indi [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to provide treatments/services, that included routine Activities of Daily Living [ADL] and skin/wound treatments to meet the resident needs for four of four sampled residents (Resident 171, 186, 10, and 57) with appropriate competencies and skills set to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident by failing to ensure: Resident 171, who is a double amputee (surgical removal of a body part such as leg) had to wait for staff to respond to call lights. Resident 186 ' who did not have a pressure ulcer on admission to the facility did not develop a Stage 2 (partial-thickness of skin, presenting as a shallow open sore or wound) coccyx (tailbone) pressure ulcer that worsened to a Stage 3 pressure ulcer (full-thickness loss of skin, dead and black tissue may be visible). Resident 10 ' s incontinent brief (brief used for anyone without control of bowel and bladder) changed when wet and soiled after recently returning to the facility after transferred to the General Acute Care Hospital (GACH) for a Urinary tract infection (UTI, an infection in the bladder/urinary tract) Resident 57 ' s incontinent brief was changed timely to prevent development of MASD (moisture associated skin damage caused from prolonged exposure to moisture) and recurrent UTIs from not being changed timely. Certified Nursing Assistant (CNA 3) during the night shift (11:00 PM to 7:00 AM) in Nursing Station 4 was not physically in the building during break time and did not inform the licensed nurse of CNA 3 ' s location. These deficient practices resulted in the residents not to receive the care and treatments to prevent skin breakdown or worsening of the skin breakdown, infections and not to immediately receive care for their activities of daily living. Cross referenced to F686, F690, and F919 Findings: 1. During a review of Resident 171 ' s Admission Record, the facility admitted Resident 171 on 1/3/2025 and readmitted Resident 171 on 2/6/2025 with diagnoses that included infection of the amputation stump, left lower extremity, and infection of amputation stump, right lower extremity. During a review of Resident 171 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 2/6/2025, the H&P indicated Resident 171 had the capacity to understand and make decisions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 171 ' s Minimal Data Set (MDS, a resident assessment), dated 1/20/2025, the MDS indicated Resident 171 ' s did make decisions regarding tasks of daily life but had some difficulty make decisions in new situations. The MDS indicated Resident 171 was dependent (helper does all the effort) on staff for all activities of daily living (ADLs, activities such a bathing, dressing, and toileting, a person performs daily) and was dependent on staff when he was lying on his back and turning on his left or right side and when transferring from chair to bed or chair to chair. During a review of Resident 171 ' s care plan, dated 1/7/2025, the care plan indicated Resident 171 was at risk for falls due to impaired mobility. The care plans interventions included to assist resident getting in and out of bed with staff, place the call light within reach while in bed or in close proximity to the bed, monitor for and assist toileting needs, and to remind resident to use call light when attempting to ambulate (walk) or transfer from bed to chair. During an observation and interview at 2/26/2025 at 5:45 PM in Resident 171 ' s room, Resident 171 was observed pressing the call light (a button or a switch used by patients to call for assistance from the staff) for assistance. Resident 171 stated, when he presses the call light for assistance, sometimes it takes them a while to come help me. During an observation at 2/26/2025 at 6 PM in the nurse ' s station, Resident 171 ' s call light was flashing and ringing on the control panel. There was no Certified Nurse Assistant (CNA) or Licensed Vocational Nurse (LVN) at the nurse ' s station. During an interview on 2/26/2025 at 6:05 PM with CNA 15, CNA 15 stated, she did not see Resident 171 ' s call light in the nurse ' s station. CNA 15 stated, she only knew Resident 171 ' s call light was on by passing by Resident 171 ' s room and looking at the call light indicator above Resident 171 ' s bed. During an interview on 2/26/2025 at 6:15PM with Registered Nurse (RN) 3, RN 3 stated, sometimes there was not enough staff to answer call lights timely because the CNAs and the Licensed Nurses could be in their individual resident ' s room assisting another resident, therefore missing another resident ' s call for assistance leading to an unmet need. 50203 2. During a review of Resident 186 ' s Admission Record, the facility admitted Resident 186 on 1/31/2025 with diagnoses that included acute respiratory failure (ARF, when the lungs have trouble getting enough oxygen [odorless gas needed for plant and animal life] into the blood) with hypoxia, muscle weakness, and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 186 ' s H&P, dated 1/31/2025, Resident 186 had the capacity to understand and make decisions. The H&P indicated Resident 186 had no skin breakdown and skin was intact. During a review of Resident 186 ' s Braden Scale for Predicting Pressure Sore Risk Original (Braden Scale, Standardized and evidence-based assessment tool to assess a resident ' s risk of developing pressure ulcers, dated 1/31/2025, the Braden Scale indicated Resident 186 was at mild risk for developing pressure ulcer. The Braden Scale indicated Resident 186 ' s skin was occasionally moist, and Resident 186 was able to make small frequent movement while confined to her bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Nursing Progress Notes, dated 2/1/2025, Treatment Nurse (TXN) 2 indicated Resident 186 had a coccyx (tailbone) Stage 2 pressure ulcer (partial-thickness loss of skin, presented as a shallow open sore or wound) sized 2 centimeters (cm, unit of measure) by 2 cm by 0.1 cm, with 100% pink wound bed. During a review of Resident 186 ' s Wound Assessment, dated 2/6/2025, evaluated by Physician Assistant (PA) 1, PA 1 indicated Resident 186 had a Stage 2 pressure ulcer on her coccyx with light serosanguinous (thin watery fluid pink in color) drainage. PA 1 indicated Resident 186 ' s pressure ulcer wound edges were macerated (a process where the skin becomes softened and breaks down due to prolonged exposure to moisture) and easily irritated. During a review of Resident 186 ' s Minimum Data Set (MDS, a resident assessment), dated 2/6/2025, the MDS indicated Resident 186 ' s cognition was intact. The MDS indicated Resident 186 was dependent on staff for ADLs, and Resident 186 required substantial assistance (helper does more than half the effort) for functional mobility (a person ' s ability to move safely and independently within their environment). The MDS indicated Resident 186 was always incontinent (involuntary loss of bladder or bowel control) for urine and stool. The MDS indicated Resident 186 was at risk for developing pressure ulcers. During an interview on 2/27/2025 at 4:30 PM with CNA 7, CNA 7 stated, there were not enough CNAs to change and turn the residents every two hours during the afternoon and night shift. CNA 7 stated, sometimes when CNAs and Licensed Nurses were helping a resident change their soiled adult brief on one end of the hallway, and the resident who pressed the call light on the opposite side of the hallway must wait until there was another CNA or Licensed Nurse available. CNA 7 stated, sometimes the residents may have to wait the about 20-40 minutes for a CNA or Licensed Nurse to help. During an interview on 2/27/2025 at 4:35PM with CNA 7, CNA 7 stated, residents who have sensitive skin were at increased risk for skin breakdown especially if the residents had been sitting in their soiled and wet adult briefs for long periods of time. 3. During a review of Resident 10 ' s Admission Record, the facility admitted Resident 10 on 3/20/2018 and readmitted on [DATE] with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract) and muscle weakness. During a review of Resident 10 ' s H&P, dated 1/15/2025, the H&P indicated Resident 10 did not have the mental capacity to make medical decisions. During a review of Resident 10 ' s MDS, dated [DATE], the MDS indicated Resident 10 ' s cognitive skills were severely impaired, and Resident 10 was dependent on staff for toileting hygiene and required supervision to extensive assistance from the staff for ADLs. The MDS indicated Resident 10 was frequently incontinent (loss of control) of bladder and bowel. During an interview on 2/26/2025 at 6:45 PM with Family Member (FM) 2, FM 2 stated, she was concerned with the care of Resident 10. FM 2 stated, she often found Resident 10 in her soiled or wet adult briefs when she visited Resident 10. FM 2 stated, she was concerned Resident 10 had recurrent UTIs while in the facility. FM 2 stated, Resident 10 was recently transferred to GACH in January 2025 for a UTI. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 2/28/2025 at 1:45 PM with CNA 13, indicated in the Documentation Survey Reports Personal Hygiene that Resident 10 was dependent on staff for incontinence care and adult brief changes. CNA 13 stated, residents who were incontinent were required to be checked at least every two hours or as needed. CNA 13 stated, there was low staffing during the night shift and has received Resident 10 with her adult briefs extremely soiled. CNA 13 stated, due to staffing shortages, Resident 10 was sometimes left in her wet or soiled adult brief for longer periods of time. 4. During a review of Resident 57 ' s Admission Record, the facility admitted Resident 57 on 1/17/2018 and readmitted on [DATE] with diagnoses including UTIs and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 57 ' s H&P, dated 9/25/2024 indicated, Resident 57 did not have the mental capacity to make medical decisions. During a review of Resident 57's MDS, dated [DATE], indicated the Resident 57 ' s cognition was severely impaired and was dependent on two persons for bed mobility, transfer, dressing, eating, and toileting. The MDS indicated the Resident 57 had an indwelling catheter (a thin, flexible tube that drains urine from the bladder) and was incontinent of bowel. During an interview on 2/26/205 at 6:45 PM with FM 3, FM 3 stated, Resident 57 had developed a MASD (moisture associated skin damage caused from prolonged exposure to moisture) and recurrent UTIs. FM 3 stated, she often found Resident 57 in a wet adult brief, which she believed was due to poor incontinent care. During a concurrent record review and interview on 2/28/2025 at 2:55 PM with Licensed Vocational Nurse (LVN) 12, Resident 57 ' s Change of Condition (CoC) documentation and physician orders were reviewed. LVN 12 stated, Resident 57 had a suprapubic (a thin flexible tube that drains urine from the bladder through a small incision in the lower abdomen) indwelling catheter and was dependent on staff for incontinence care and diaper changes. LVN 12 stated, Resident 57 had recurrent UTIs and recently developed MASD. LVN 12 stated, Resident 57 ' s UTIs and MASD may be a result of Resident 57 lying in his soiled and wet adult briefs for long periods of time due to low staffing, especially during the night shift. During a concurrent interview and record review on 3/1/2025 at 11:30AM with the Director of Satff Development (DSD), dated 2/8/2025, 2/9/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/19/2025, 2/23/2025, 2/24/2025, and 2/25/2025 were reviewed. The DSD stated the Licensed Nurses and the CNAs were both understaffed on these days. During an interview on 3/1/2025 at 11:45AM, the DSD stated, if the Licensed Nurses and the CNAs were insufficiently staffed, it means the residents were not getting their needs met due to short staffing. The DSD stated, examples of resident ' s needs not being met could include residents who had wet and soiled adult briefs were not changed frequently, call lights were not answered timely, or residents were getting their medications late. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During the group interview for the facility ' s resident council on 2/25/2025 at 2:45 PM with 12 alert and oriented residents, nine out of 12 residents stated the facility was short staffed especially during the night shift. Resident 44 stated he fell out of bed during the night shift, called for assistance using the call light, but staff did not arrive to assist the resident, prompting Resident 44 to call 911 (emergency services). During a review of the Nursing Staff Assignment, dated 2/25/2025, for the 11 PM to 7:30 AM shift, the Nursing Staff Assignment for CNA 3 included Resident During the group interview for the facility ' s resident council on 2/25/2025 at 2:45 PM with 12 alert and oriented residents, nine out of 12 residents stated the facility was short staffed especially during the night shift. Resident 44 stated he fell out of bed during the night shift, called for assistance using the call light, but staff did not arrive to assist the resident, prompting Resident 44 to call 911 (emergency services). During a review of the Nursing Staff Assignment, dated 2/25/2025, for the 11:00 PM to 7:30 AM shift, the Nursing Staff Assignment for CNA 3 included Resident 44 and Resident 96. The Nursing Staff Assignment indicated CNA 3 ' s actual meal break was from 3:30 AM to 4:00 AM. During a review of Resident 44 ' s Admission Record (AR), the AR indicated the facility readmitted Resident 44 on 9/10/2024 with diagnoses that included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension. During a review of Resident 44 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 12/6/2024, the MDS indicated Resident 44 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (ability to think, understand, learn, and remember). During a review of Resident 96 ' s AR, the AR indicated the facility admitted Resident 96 on 9/22/2024 with diagnoses including complete paraplegia (loss of movement and sensation of the legs). During a review of Resident 96 ' s MDS, dated [DATE], the MDS indicated Resident 96 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition. During a concurrent observation and interview on 2/26/2025 at 6:22 AM in the front lobby, CNA 3 walked into the facility holding a coffee cup from a local convenience store. CNA 3 stated she returned from a break. During an interview on 2/26/2025 at 6:43 AM with CNA 3, CNA 3 stated lunch was a scheduled time but break times were not scheduled and varied during the shift. During an interview on 2/26/2025 at 6:45 AM with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated the CNAs (in general) had a 30-minute lunch and a 15-minute break. LVN 6 stated the CNAs could have lunch or break in the break room or in their cars. LVN 6 stated none of the CNAs during the night shift reported they were going to their car for lunch or break. During an interview on 2/26/2025 at 6:49 AM with CNA 3, CNA 3 stated she did not tell anyone she was in the car for break time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2025 at 7:42 AM with LVN 6, LVN 6 stated none of the CNAs reported taking a break outside in their car. LVN 6 stated CNAs were supposed to inform LVN 6 of their location during breaktimes, including leaving the facility to take a break in their cars outside, to ensure the residents have adequate supervision and for other facility staff to check on the residents. During an interview on 2/27/2025 at 8:50 AM in Resident 96's room, Resident 96 stated she pressed the call light during the night (of 2/25/2025) at approximately 11:00 PM for Resident 96 ' s roommate. Resident 96 stated CNA 3 answered the call light after 45 minutes. During an interview on 2/28/2025 at 10:41 AM in Resident 44 ' s room, Resident 44 stated CNA 3 has been more attentive lately but sometimes disappeared during the night shift. During an interview on 2/28/2025 at 5:21 PM with the Administrator (ADM) and the Regional Clinical Resource Registered Nurse (RCR), the ADM stated the facility staff could take breaks outside in their car after informing the supervising nurse. The RCR stated there was a potential the residents needs would not be met if the staff took breaks outside in their car without informing the supervising nurse. During a review of the facility's Policy and Procedure (P&P) titled, Staffing, revised 10/2017, the P&P indicated the facility provided sufficient nursing of staff to provide care and services for all residents. The P&P indicated licensed nursing and certified nursing assistants are available 24 hours a day to provide direct resident care services. During a review of the facility ' s P&P, titled Staffing, dated 10/2017, the P&P indicated our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. The P&P indicated, staffing numbers and skill requirements of direct care staff are determined by the needs of the residents based on each resident ' s plan of care. During a review of the facility ' s P&P, titled Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated the facility will provide appropriate care and services for residents who were unable to carry out their ADLs independently with the consent of the resident and in accordance with the plan of care, including: Elimination (toileting); staff will do rounds prior to all meals to ensure that ADL needs are met. During a review of the facility's P&P, titled Call System, Resident, dated 9/2022, the P&P indicated calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. During a review of the facility's policies and procedures (P&P), titled Answering the Call Light, dated 10/24/2024, the P&P indicated to ensure timely responses to the resident ' s requests and needs.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47467 Based on interview, and record review, the facility failed complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of the areas concern at the facility by failing to: 1. Complete a performance/competency review for two sampled Certified Nurse Assistants (CNAs) and one Licensed Vocational Nurse (LVN). The CNAs and LVN did not have a completed Annual Core Clinical Competencies (ACCC, an assessment and training on the nursing staffs the ability to perform clinical nursing care). 2. Develop a system to keep track of the facility ' s ACCC to make sure all CNAs and LVNs to be evaluated annually. This deficient practice had the potential for the residents not to receive based on the standard of professional practice, residents care plans, physician ' s orders and the facility ' s policy and procedures and the Facility Assessment (an assessment to make decisions about direct care staff needs, as well capabilities to provide services to the residents) from the nursing staffs (CNAs and LVNs) not able to provide quality care to the resident ' s population. Findings: During an interview on 2/27/2025 at 6:35 AM with Certified Nurse Assistant (CNA) 16, CNA 16 stated, she had not had her skills competency evaluated annually. During an interview on 2/27/2025 at 6:43 AM with Licensed Vocational Nurse (LVN) 13, LVN 13 stated, he had been working for two years and had not had his competency skill evaluated annually. During an interview on 2/27/2025 at 5:15 PM with CNA 17, CNA 17 stated, she had been working at the facility for two years and had not attended an ACCC. CNA 17 stated, it would be nice to have her skills competency evaluated to see how she was doing and received feedback to improve. During a concurrent record review and interview on 2/28/2025 at 3:15 PM with the Regional Clinical Resource (RCR), nine (9) sampled CNAs including CNA 16 and CNA 17 were selected to review their annual competency evaluation records. The RCR stated, she did not have the ACCC records for the 9 selected CNAs. During an interview on 2/28/2025 at 3:45 PM with the RCR, the RCR stated, the previous Director of Staffing Development (DSD) left around November 2024, and she only came in the facility a few days a week. The RCR stated, when the new management took over about three months ago, the facility found out that the CNAs and LVNs ' records to verify the licenses, background checks, certifications, in-services, and ACCC were missing and not kept on track. The RCR stated, she had not yet created a spreadsheet or a system with a list of all their nursing staffs to keep track of the ACCC. The RCR stated, it was important to have their nursing staffs evaluated for skills competency annually to make sure their skills were up to date and that the nursing staffs were competent in taking care of the facility ' s population. (continued on next page)

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	056487	A. Building B. Wing	03/01/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled, Job Descriptions and Performance Evaluations, revised September 2020, indicated performance evaluations measure the standards against job performance.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or (5%) or less during medication pass for two of four observed residents (Residents 111 and 113) in which eight (8) medication errors were identified out of 29 opportunities which yielded a cumulative error rate of 27.59 %. The facility failed to ensure: 1. The Licensed Vocational Nurse (LVN) 3 did not mix Keppra (medication given to treat seizures-[sudden, uncontrolled electrical discharges in the brain that can cause changes in behavior, movement, sensation, or consciousness]), multivitamins and Phenytoin (medication given to prevent seizures) in a 5 oz cup before administering via gastrostomy tube (GT- a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow) to Resident 133. 2. LVN 4 did not mix all prescribed medications together in one cup before administration via GT from Resident 111. 3. LVN 3 and LVN 4 did not stop the tube feeding at least one hour before and after administering Phenytoin according to the physician ' s order and pharmaceutical recommendations. These deficient practices had the potential to result in inconsistent medication administration, risks of medication interactions (occurs when a drug reacts with another drug, that cause the drug to be less or more effective or cause unexpected side effects) and compromised drug absorption, altered drug responses, and clog the GT which requires repeat GT insertion. Cross reference with F760 Findings: 1. During a review of Resident 133 ' s Admission Record (Face Sheet), indicated the facility admitted the resident on 5/4/2024 and readmitted on [DATE] with diagnoses including convulsions (involuntary muscle shaking due to uncontrolled activity in the brain), and seizures. During a review of Resident 133 ' s History and Physical (H&P), dated 1/8/2025 indicated, Resident 133 does not have the mental capacity to make medical decisions. During a review of Resident 133's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/18/2025, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and was dependent on staff for the activities of daily living. During a review of Resident 133's Order Summary, dated 5/21/2024, the Order Summary Report indicated the resident was prescribed the following medications: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ferrous Sulfate (medication use to treat/prevent low iron) Oral Solution 5 mg(milligram)/20ml(milliliters) Give 5 ml by mouth one time a day for supplement with a Start Date 2/13/2025 Keppra Oral Solution 100 mg/ml (Levetiracetam) Give 5 ml via GT two times a day for seizures with a Start Date 2/13/2025 Multivitamin & Mineral Oral Liquid Give 15 ml via GT one time a day for supplement. Start date 2/13/2025. Senna Oral Tablet- give 1 tablet via GT one time a day for constipation hold if loose stool Phenytoin Oral Suspension 125 MG/5ML (Phenytoin) Give 5 ml via GT three times a day for seizures. Start date 2/13/2025. Metoprolol Tartrate (Medication use to help lower blood pressure) Oral Tablet 50 mg Give 1 tablet via GT three times a day for tachycardia hold If SBP less than 110 or HR less than 60. Start date 2/13/2025. Pantoprazole (treats heartburn [a burning feeling in the chest]) Sodium Oral Tablet Delayed Release 40mg (Pantoprazole Sodium) Give 1 tablet via GT one time a day for Increased gastric acid. Start date 2/13/2025. Baclofen (muscle relaxants) Oral Tablet 10mg Give 1 tablet by mouth two times a day for muscle spasm. Start date 2/13/2025. Lactobacillus Oral Capsule (probiotic- stomach bacteria) Give 1 capsule via GT one time a day for GI health Start date 2/13/2025. During a medication pass observation on 2/26/2025 at 9 AM, LVN 3 prepared the following medications for Resident 133 to be administered via GT: Baclofen, Keppra, Lactobacillus, Metoprolol, Multivitamin, Phenytoin, Ferrous Sulfate, and Pantoprazole. LVN 3 then mixed Multivitamins, Keppra and Phenytoin in a 5 ounces medication cup. During a medication pass observation on 2/26/2025 at 9:05 AM, prior to administration of medications to Resident 133, LVN 3 was stopped prior to administration of Multivitamins, Keppra and Phenytoin. LVN 3 did not stop the tube feeding one to two hours before and after administration of medications. During an interview on 2/26/2025 at 9:10AM, LVN 3 stated, that Multivitamins, Keppra and Phenytoin should not have been mixed together. LVN 3 stated she did not stop the tube feeding one hour before administering Phenytoin because I didn ' t think it was necessary. During an interview on 2/26/2025 at 9:25AM with Registered Nurse (RN) 1, RN 1 stated that medications should not be mixed together before administering via GT, and the staff should follow facility ' s policy and procedure which required separating administrations of Multivitamins, Keppra and Phenytoin to prevent medication interactions (occurs when a drug reacts with another drug, that cause the drug to be less or more effective, or cause unexpected side effects) and compromised drug absorption. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 111 ' s Admission Record, the facility admitted Resident 111 on 3/15/2023 and readmitted on [DATE] with diagnoses including seizures and respiratory failure. During a review of Resident 111 ' s, H&P, dated 1/7/2025 indicated, Resident 111 does not have the mental capacity to make medical decisions. During a review of Resident 111 ' s MDS, dated [DATE], indicated the cognitive skills for daily decisions making was severely impaired, and needed dependent on staff for the activities of daily living. During a review of Resident 111's Order Summary, dated 2/11/2025, the Order Summary Report indicated the resident was prescribed the following medications: Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin-Hypromellose-Polyethylene Glycol 400) Instill 2 drop in both eyes two times a day for dry eyes management, wait 3 minutes between drops. Levetiracetam (Keppra) oral solution 100 mg/ml give 10 ml via GT every 12 hours for seizure Phenytoin oral Suspension 100 mg/4ml give 250 mg via GT two times a day for Seizure management, 10ML =250mg shake well before medication administration, hold feeding for one hour before and after administration. Pantoprazole Sodium Oral Packet 40 mg give 1 packet via GT one time a day for Gastroesophageal reflux disease (GERD- s a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach) management, mix with 5ml of apple juice, do not prepare using any other liquids or foods including water, after administering medication flush GT with additional apple juice to clear tube. UTI (an infection in any part of the urinary system that includes the kidneys, ureters, bladder and urethra) Stat Oral Liquid (Cranberry-Vitamin C-Inulin) Give 30 ml via GT one time a day for supplement UTI prophylaxis (prevention) During a concurrent observation and interview on 2/27/2025 at 9:50AM, LVN 4 was observed preparing and administering medications for Resident 111. LVN 4 prepared the medication and combined all medications in a 5-oz medication cup to be administered to Resident 111 via GT. LVN 4 stated, I ' ve always mixed medications together in a medication before giving them to the residents, and I ' ve never had an issue. LVN 4 stated she stopped the tube feeding at 9:17AM (33 minutes prior to administering Phenytoin) and she was not aware of the physician ' s order that the tube feeding had to stop one hour before administering Phenytoin. During a telephone interview on 2/27/2025 at 3:30PM with the Pharmacist Consultant (PC), the PC stated that medications should not be mixed together due to a potential drug interaction, which may alter drug effectiveness and increase the risk of clogging the GT. PC stated, that mixing medications is not recommended, and that each medication should be administered separately with appropriate flushing of the GT. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an enteral tubbing, revised 2018, indicated to Administer each medication separately and flush between medications. During a review of Medline Plus (National Library of Medicine online) recommendations for Phenytoin it indicated, if you are receiving formula or supplements through a feeding tube, talk to your doctor about when you should take phenytoin. You will need to allow some time between receiving your feedings and taking phenytoin. https://medlineplus.gov/druginfo/meds/a682022.html

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on interview and record review the facility failed to ensure two out of four residents (Resident 111 and 113) were free from significant medication errors as indicated in the physician's order, pharmacy recommendation and facility's policy and procedures by failing to ensure: 1. The Licensed Vocational Nurse (LVN) 3 did not mixed Keppra (medication given to treat seizures-[sudden, uncontrolled electrical discharges in the brain that can cause changes in behavior, movement, sensation, or consciousness]), multivitamins and Phenytoin (medication given to prevent seizures) in a 5 oz cup before administering via gastrostomy tube (GT- a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow) to Resident 133. 2. LVN 4 did not mixed all prescribed medications together in one cup before administration via GT for Resident 111. 3. LVN 3 and LVN 4 did not stop the tube feeding at least one hour before and after administering Phenytoin according to the physician's order for Resident 111 and pharmaceutical recommendations for Resident 133. These failures had the potential for the residents to be at risk for medication errors, reduced drug effectiveness, potential toxicity, and tube clogging, which could lead to nutritional deficiencies, treatment failure, and medical complications. Findings: During a review of Resident 133 ' s Admission Record (Face Sheet), indicated the facility admitted the resident on 5/4/2024 and readmitted on [DATE] with diagnoses including convulsions (involuntary muscle shaking due to uncontrolled activity in the brain), and seizures. During a review of Resident 133's History and Physical (H&P), dated 1/8/2025 indicated, Resident 133 does not have the mental capacity to make medical decisions. During a review of Resident 133's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/18/2025, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and was dependent on staff for the activities of daily living. During a review of Resident 133's Order Summary, dated 5/21/2024, the Order Summary Report indicated to administer the following medications to the resident: -Keppra Oral Solution 100 mg/ml (Levetiracetam) Give 5 ml via GT two times a day for seizures with a Start Date 2/13/2025 -Multivitamin & Mineral Oral Liquid Give 15 ml via GT one time a day for supplement. Start date 2/13/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Phenytoin Oral Suspension 125 MG/5ML (Phenytoin) Give 5 ml via GT three times a day for seizures. Start date 2/13/2025. During a medication pass observation on 2/26/2025 at 9 AM, LVN 3 prepared the following medications for Resident 133 to be administered via GT: Baclofen, Keppra, Lactobacillus, Metoprolol, Multivitamin, Phenytoin, Ferrous Sulfate, and Pantoprazole. LVN 3 then mixed Multivitamins, Keppra and Phenytoin in a 5 ounces medication cup. During a medication pass observation on 2/26/2025 at 9:05 AM, prior to administration of medications to Resident 133, LVN 3 was stopped prior to administration of Multivitamins, Keppra and Phenytoin. LVN 3 did not stop the tube feeding one to two hours before and after administration of medications. During an interview on 2/26/2025 at 9:10AM, LVN 3 stated, that Multivitamins, Keppra and Phenytoin should not have been mixed together. LVN 3 stated she did not stop the tube feeding one hour before administering Phenytoin because I didn ' t think it was necessary. During an interview on 2/26/2025 at 9:25AM with Registered Nurse (RN) 1, RN 1 stated that medications should not be mixed together before administering via GT, and the staff should follow facility ' s policy and procedure which required separating administrations of Multivitamins, Keppra and Phenytoin to prevent medication interactions (occurs when a drug reacts with another drug, that cause the drug to be less or more effective, or cause unexpected side effects) and compromised drug absorption. 2. During a review of Resident 111 ' s Admission Record, the facility admitted Resident 111 on 3/15/2023 and readmitted on [DATE] with diagnoses including seizures and respiratory failure. During a review of Resident 111 ' s, H&P, dated 1/7/2025 indicated, Resident 111 does not have the mental capacity to make medical decisions. During a review of Resident 111 ' s MDS, dated [DATE], indicated the cognitive skills for daily decisions making was severely impaired, and needed dependent on staff for the activities of daily living. During a review of Resident 111's Order Summary, dated 2/11/2025, the Order Summary Report indicated to administer the following medications to the resident: Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin-Hypromellose-Polyethylene Glycol 400) Instill 2 drop in both eyes two times a day for dry eyes management, wait 3 minutes between drops. -Levetiracetam (Keppra) oral solution 100 mg/ml give 10 ml via GT every 12 hours for seizure -Phenytoin oral Suspension 100 mg/4ml give 250 mg via GT two times a day for Seizure management, 10ML =250mg shake well before medication administration, hold feeding for one hour before and after administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pantoprazole Sodium Oral Packet 40 mg give 1 packet via GT one time a day for Gastroesophageal reflux disease (GERD- s a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach) management, mix with 5ml of apple juice, do not prepare using any other liquids or foods including water, after administering medication flush GT with additional apple juice to clear tube. UTI (an infection in any part of the urinary system that includes the kidneys, ureters, bladder and urethra) Stat Oral Liquid (Cranberry-Vitamin C-Inulin) Give 30 ml via GT one time a day for supplement UTI Prophylaxis (prevention) During a concurrent observation and interview on 2/27/2025 at 9:50AM, LVN 4 was observed preparing and administering medications for Resident 111. LVN 4 prepared the medication and combined all medications in a 5-oz medication cup to be administered to Resident 111 via GT. LVN 4 stated, I ' ve always mixed medications together in a medication before giving them to the residents, and I ' ve never had an issue. LVN 4 stated she stopped the tube feeding at 9:17AM (33 minutes prior to administering Phenytoin) and she was not aware of the physician ' s order that the tube feeding had to stop one hour before administering Phenytoin. During a telephone interview on 2/27/2025 at 3:30PM with the Pharmacist Consultant (PC), the PC stated that medications should not be mixed together due to a potential chemical interaction, which may alter drug effectiveness and increase the risk of clogging the GT. PC stated, that mixing medications is not recommended, and that each medication should be administered separately with appropriate flushing of the GT. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an enteral tubing, revised 2018, indicated to Administer each medication separately and flush between medications. During a review of Medline Plus (National Library of Medicine online) recommendations for Phenytoin it indicated, if you are receiving formula or supplements through a feeding tube, talk to your doctor about when you should take phenytoin. You will need to allow some time between receiving your feedings and taking phenytoin. https://medlineplus.gov/druginfo/meds/a682022.html

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review the facility failed to store prescription medications in a safe place for one of 8 sampled residents (Resident 391), who was found with prescription medications on top of the bedside drawer on 2/25/2025 in accordance with the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 2008, This failure had a potential to result in accidental consumptions and result in adverse reactions (undesired effects) from medication and harms for any residents and visitors who walked into Resident 391 ' s room and take the prescription medications. Findings: During a review of Resident 391 ' s Admission Record, indicated Resident 391 was admitted to the facility on [DATE] with diagnosis that included bilateral primary osteoarthritis (a common joint disease that causes the breakdown of cartilage, the protective tissue that cushions the ends of bones) of knee, hypertension (high blood pressure), and dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities. During a review of Resident 391 ' s History and Physical Examination, dated 2/25/2025, indicated Resident 391 did not have the capacity to understand and make decisions. During an observation on 2/25/2025 at 10:02 AM in Resident 391 ' s room, Resident 391 was sleeping in bed, four prescription medication bottles including Levothyroxine (medication for hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone) 75 mcg (unit of weight), Terbinafine HCL (medication to treat fungal infection) 250mg tab were on top of the beside drawer. During a concurrent observation and interview on 2/25/2025 at 4:25 PM in Resident 391 ' s room with Licensed Vocational Nurse (LVN) 5, four bottles of prescription medications were on top of Resident 391 ' s bedside drawer. LVN 5 asked Resident 391 how long her medications were at the bedside. Resident 391 stated, she was admitted the night before (2/24/2025) with her prescription medications. During a concurrent record review and interview on 2/25/2025 at 4:40 PM with LVN 5, Resident 391 ' s Belonging List was reviewed. LVN 5 stated, Resident 391 ' s belonging list should have been completed right upon admission, which should include her prescription medications. LVN 5 stated, Resident 391 ' s prescription medication bottles should be kept in a safe place, not at the resident ' s bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 4:34 PM with the Acting Director of Nursing (ADON), the ADON stated, the admitting staff should complete Resident 391 ' s belonging list right upon admission that included her prescription medications. The ADON stated, the prescription medications needed to be kept in a safe box to limit access from other residents and visitors. The ADON stated, confused residents that walked around could enter the room and took the medications, which could potentially harm them. During a review of the facility ' s Policy and Procedure (P&P) titled, Medication Storage in the Facility, dated 2008, indicated only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 47467 Based on interview and record review, the facility failed to ensure no delay in informing the physician about critical lab results for one of three sampled residents (Resident 180), who had critical lab values of white blood cell (WBC, a type of blood cell that helps fight infection and disease) count and low blood glucose (BG, the main sugar found in the blood), which were reported on 2/23/2025 at 11:48 PM as evidenced by the critical lab results were not followed up with Resident 180 ' s covering physician [Nurse Practitioner (NP) 1] until 2/24/2025 at 2:36 PM (approximately 14.5 hours when the critical lab results were reported). This deficient practice had a potential to result in a delay in care, interventions and treatment. Cross reference to F690, F842 Findings: During a review of Resident 180's Admission Record (AR), the AR indicated the facility admitted Resident 180 on 1/29/2025 with diagnoses that included pneumonia (a severe an infection of the lungs that may be caused by bacteria, viruses, or fungi), sepsis (a life threatening infection in the blood which could lead to decreased in blood pressure (BP), increased heart rate (HR), shortness of breath and altered level of consciousness, that can damage the body organs). During a review of Resident 180 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated 2/4/2025, indicated Resident 180 ' s cognition (ability to think, remember, and reason with no difficulty) was intact and needed partial assistance (helper does less than half the effort) in eating and personal hygiene. During a review of Resident 180 ' s phone orders, dated 2/22/2025, indicated Resident 180 had a physician order on 2/22/2025 at 7:39 PM for CBC (complete blood count, a blood test that measures the number and size of different types of blood cells), CMP (a routine blood test that measures 14 different substances in a sample of the blood), and UA with C&S (urinalysis with culture and sensitivity). During a review of Resident 180 ' s Laboratory Results Report, dated 2/23/2025 timed at 11:48 PM, indicated Resident 180 had critical lab values for BG level of 60 milligrams (unit of weight) per deciliter (a metric unit of capacity) (mg/dL- reference range 65-99 mg/dL) and WBC count of 39.59 cells per microliter (unit of volume) of blood (normal reference range was 4-11 cells per microliter of blood). During a review of Resident 180 ' s Change in Condition (CIC) Evaluation, dated 2/24/2025, indicated Resident 180 had critical lab results with low glucose of 60, high WBC of 39.59 with no fever, clear breath sounds, and vital signs within normal range. The CIC indicated, on 2/24/2025 at 2:48 AM, LVN 5 notified Resident 180 ' s Nurse Practitioner (NP) 1 about critical lab results of low blood glucose and high WBC and received a new order for antibiotics (medication given to treat infection). Further review of the CIC indicated no order was written for antibiotics. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 180 ' s Follow-up Documentation for the CIC of critical lab results of low BG and high WBC, dated 2/24/2025, timed at 2:36 PM, the document indicated LVN 10 followed up with NP 1 for abnormal labs with no new order and to continue to monitor Resident 180. During a concurrent record review and interview on 2/25/2025 at 1:05 PM with LVN 5, Resident 180's CIC Evaluation, dated 2/24/2025, timed at 3:31 AM was reviewed. LVN 5 stated, she worked as a Desk Nurse during the day, who was responsible to assist the Charge Nurses in communicating with the doctors. LVN 5 stated, she only worked dayshift and was not working at nighttime on 2/23/2025 and 2/24/2025. LVN 5 stated, in the morning of 2/25/2025, she noticed that there was an incomplete CIC which was created on 2/24/2025 at 3:31 AM for critical lab results of low glucose and high WBC. LVN 5 stated, the CIC indicated that on 2/24/2025 at 2:28 AM, Resident 180 ' s physician was messaged and was still waiting for response, so she called Resident 180 ' s covering physician (NP 1) to report the critical lab results as a follow up and received a physician order for antibiotics around 9:30 AM. LVN 5 stated, on 2/25/2025, after she received order for antibiotics, she revised the physician recommendations on 2/24/2025 at 2:48 AM from waiting for response to NP 1 made aware with new orders for IV antibiotic. LVN 5 stated, she forgot to change the physician notification time from 2/24/2025 at 2:48 AM to 2/25/2025 at 9:30 AM. During an interview on 2/27/2025 at 5:12 PM with LVN 10, LVN 10 stated, he took care of Resident 180 from 7 AM to 3 PM on 2/24/2025. LVN 10 stated during the first or second hour of his shift, the RN supervisor gave him lab results and asked him to wait for the physician to respond so he did not call NP 1 to follow up with the critical lab results in the morning of 2/24/2025. LVN 10 stated, Resident 180 was alert and responded to verbal command at the start of his shift. LVN 10 stated, around 2 PM, Resident 180 was slightly lethargic with generalized weakness, and elevated temperature so he notified NP 1 and followed up with the critical lab results and received order to monitor. During an interview on 2/28/2025 at 4:44 PM with the Acting Director of Nursing (ADON), the ADON stated, critical lab results must be reported to the physician promptly to avoid delay in treatment. During a review of the facility ' s policy and procedures (P&P) titled, Test Results, revised 2007, indicated: The resident ' s Attending Physician will be notified of the results of diagnostic tests; Should the test results be provided to the facility, the Attending Physician shall be promptly notified of the results; and, the Director of Nursing Services, or Charge Nurse receiving the test results, shall be responsible for notifying the Physician of such test results.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42878 Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu was followed on 2/25/2025 when food items listed on the resident menu were not available and were replaced by alternative menu without the Registered Dietician (RD) approval. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake, weight loss in 14 residents out of 142 residents. Findings: During a review of the facility ' s P&P titled Menus, revised on 10,2022, the P&P indicated Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with the established national guidelines. Menus will be developed to meet the criteria through the use of an approved planning guide. During a review of the facility lunch menu for 2/25/2025, the following food items would be served. Regular diet: beef soft taco with flour tortillas (2 each), garlic green beans 1/2 cup, green Chile rice 1/2 cup. During an observation of the tray line service (a system of food preparation, in which trays move along an assembly line) for lunch, on 2/25/2025, at 1:04 PM, the cook served turkey smothered burger patty instead of beef soft tacos for 14 resident meal trays. During an interview with [NAME] (Cook1) on 2/25/2025 at 1:12 PM, Cook1 stated that he did not know why he ran out of beef for the soft tacos to serve for all the residents. Cook1 stated this had never happened before, the facility had previously used this recipe. During an interview with Dietary Supervisor (DS) on 2/26/2025 at 10:13 AM, the DS stated he was not aware why the facility ran out of beef taco meat and had to serve the residents in the last meal cart with the alternative lunch meat. The DS stated they had used this recipe before and had never run out of meat. The DS stated as it was unplanned and was not able to inform or notify the residents before or the RD before changing the menu. The DS stated he believed residents would be upset if they were looking forward to the beef tacos and were served with the alternative turkey patty without being informed, beforehand. During an interview with the RD on 2/26/2025 at 10:08 AM, the RD stated she was not aware that the facility ran out of the beef taco meat until after meals had been served to the residents. During an interview on 2/262025 at 10:31 AM with Resident 5, Resident 5 stated he was not informed the facility had run out of beef tacos before he was served lunch and would only serve the alternative Turkey Patty. Resident 5 stated it is not okay for the facility to not notify the residents prior and not give them a choice in their meal items as he was looking forward to the beef tacos for lunch. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2025 at 10:36 AM with Resident 158, Resident 158 stated the facility would often put one thing on the menu and serve something different without asking or informing the residents or giving them a choice. Resident 158 stated he was upset and surprised to receive a turkey patty for lunch yesterday instead of the beef tacos as indicated in the menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42878 Based on observation, interview, and record review the facility failed to follow proper sanitation and safe food handling by failing to: 1. Ensure pre-made cheese sandwiches found in the facility ' s walk-in refrigerator were dated and labeled with the prepared and used by dates, as indicated in the facility ' s policy and procedure (P&P) titled, Food Storage: Cold Foods. 2. Ensure the ice scoop used for scooping ice found in the ice machine was stored in a separate container when not in use, to limit exposure to dust and moisture retention, as indicated in the facility ' s P&P titled, Ice. 3. Staff wear gloves when preparing resident apple sauce cups. These deficient practices had the potential for cross contamination and put residents at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During a review of the facility ' s P&P titled Food Storage: Cold Foods with a revision date of April 2018, the P&P indicated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. During a review of the facility ' s P&P titled Ice with a revision date of 10,2022, indicated Ice will be prepared and distributed in a safe and sanitary manner. 5. Ice scoops will be cleaned and stored in a separate container that limits exposure to dust and moisture retention. During a review of the facility ' s P&P titled Food Preparation and Service, revised on November 2022, the P&P indicated Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. During an observation of the facility ' s kitchen and walk-in refrigerator on 2/25/2025 at 7:45 AM, in the presence of the Dietary Supervisor (DS), there were three cheese sandwiches observed inside plastic bags that were unlabeled and undated. During another observation, inside the facility kitchen on 2/25/2025 at 8:13 AM, the ice scoop of the ice machine was observed placed on top of a metal table next to the ice machine. The ice scoop was not stored on a separate container. During a subsequent interview with DS on 2/25/2025 at 8:13 AM, the DS stated the ice scoop should be kept in a plastic container and should not be left sitting on the metal table when not in use, to prevent cross contamination from the table to the ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/25/2025 at 9:10 AM, in the facility ' s kitchen, the DS stated the undated, unlabeled sandwiches should be dated and labeled to indicate the date prepared and date the sandwich was good to consume. During an a lunch preparation observation on 2/25/2025 at 12:19 PM in the kitchen, the Dietary Aide was observed pouring apple sauce into small individual plastic containers and not wearing food service gloves. The DA was observed using her ungloved hand by placing her index finger inside each plastic containers to separate the empty containers and proceeded to open the nearby reach-in refrigerator to get another bottle of apple sauce and then started to pour a new batch of apple sauce into the small plastic containers again. During a subsequent interview on 2/25/2025 at 12:21 PM with the DS, the DS stated all kitchen staff should be wearing food service gloves anytime they are preparing food for the residents. The DS stated when separating plastic containers used for food for the residents, kitchen staff should not be placing their fingers inside the containers. The DS stated kitchen staff should separating each container by grabbing the outside bottom of each individual container to prevent contaminating the containers from the inside.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 36943 Based on observation, interview, and record review, the facility failed to develop specific policies regarding freezer storage and implement the facility ' s current policy of storing foods brought in by residents and family members, that included one of two sampled residents (Resident 96) who use the residents ' refrigerator for food storage. This deficient practice had the potential to promote miscommunication among facility staff, residents, and families about frozen food storage and prevent frozen food from safe and sanitary storage, handling, and consumption. Findings: During a review of the facility ' s policy and procedure (P&P) titled, Food Brought by Family/Visitors, revised 3/28/2024, the P&P indicated the responsible staff member will ensure foods are in a sealed container to prevent cross contamination and will label foods with the resident ' s name, current date, and ' use by date. ' The P&P indicated items not opened can follow the manufacturer use by date and the refrigerator/freezer for storage of foods will be cleaned daily. During a review of Resident 96 ' s Admission Record (AR), the AR indicated the facility admitted Resident 96 on 9/22/2024 with diagnoses including complete paraplegia (loss of movement and sensation of the legs) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side. During a review of an undated History and Physical (H&P) Examination, the H&P indicated Resident 96 had paraplegia related to a motor vehicle accident and a stroke causing left arm paralysis. The H&P indicated Resident 96 had good function in the right arm and had the capacity to understand and make decisions. During a review of Resident 96 ' s physician orders, dated 9/22/2024, the physician orders indicated Resident 96 was on a regular texture diet with regular/thin liquid consistency. During a review of Resident 96 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 2/11/2025, the MDS indicated Resident 96 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition. The MDS indicated Resident 96 was independent with eating, required partial/moderate assistance (helper does less than half the effort) for oral hygiene and upper body dressing, and was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for lower body dressing, toileting, and chair/bed-to-chair transfers. During a concurrent observation and interview on 2/25/2025 at 12:34 PM in the Activity/Dining Room with the Regional Registered Dietitian (RRD), there were two refrigerators for the residents ' personal food storage. RRD opened the top freezer of the first refrigerator which was full. RRD stated the freezer was for residents and families who brought in food for storage. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 12:40 PM in the Activity/Dining Room with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated the Dietary Supervisor (DS) was responsible for cleaning the freezer. LVN 5 removed frozen items from the freezer for Resident 96, including the following: Five undated plastic storage bags containing one sausage with visible freezer burn without a manufacturer expiration date. One undated plastic storage bag with pancakes and sausage on a stick without a manufacturer expiration date. One undated plastic storage bag of sausages without a manufacturer expiration date. One plastic storage bag dated 10/1/2024-11/1/2024, containing frozen chocolate chip ice cream sandwiches without a manufacturer expiration date. One plastic storage bag dated 10/1/2024-11/1/2024, containing nine popsicles, without a manufacturer expiration date. One plastic storage bag, dated 12/1/2024, containing four biscuits without a manufacturer expiration date. During a concurrent observation and interview on 2/25/2025 at 12:57 PM with Resident 96 in Resident 96 ' s room, Resident 96 was awake and alert while lying in bed. Resident 96 ' s room had boxes containing chips and beverages and one tray table with containers of multiple food condiments. Resident 96 stated she was paralyzed with use of only the right arm, which was observed with full active movement. Resident 96 stated she disliked the facility ' s food and preferred personally purchased food outside the facility. Resident 96 stated the resident freezer was for long-term food storage. During an interview on 2/26/2025 at 6:21 AM with the DS, the DS stated the plastic storage bags, dated 10/1/2024 to 11/1/2024, indicated the food item was placed in the freezer on 10/1/2024 and should be used by 11/1/2024. The DS stated foods with freezer burn were not completely sealed and were improperly stored in the plastic storage bags. During an interview on 2/28/2025 at 9:47 AM with the DS, the DS stated it was the facility ' s practice to throw out stored frozen foods after one month. The DS stated the freezer was last checked on 2/22/2025 but should be checked daily. The DS stated Resident 96 ' s frozen foods that were in undated plastic storage bags, dated 10/1/2024 to 11/1/2024, and did not indicate the manufacturer expiration dates should have been thrown out to prevent food-borne illness. The DS stated the facility P&P did not include the facility ' s practice of storing freezer foods for one month and facility ' s practice to throw out stored frozen foods after one month.

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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. 36943 Based on observation, interview, and record review, the facility failed to accurately documentation for in the clinical records for two of two sampled residents (Resident 148 and 180). 1. For Resident 148 the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) Record for one of five sampled residents (Resident 148) with limitation in range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) on 2/24/2025. 2. For Resident 180 the documentation of the resident's Change in Condition Evaluation record for failed to ensure Licensed Vocational Nurse (LVN) 5 documented accurately the date and time when she notified the Resident 180 ' s Nurse Practitioner (NP) 1 on 2/25/2025 with the resident ' s critical lab results. This failure resulted in the inaccurate provision of care recorded in Resident 148 ' s and 180's clinical records and the potential to negatively impact the delivery of services. Cross reference to F690 and F773 Findings: During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, the P&P indicated all services provided to the resident shall be document in the resident ' s medical record. The P&P indicated the documentation in the medical record will be objective, complete, and accurate. During a review of Resident 148 ' s Admission Record (AR), the AR indicated the facility admitted Resident 148 on 8/12/2024 with diagnoses including ventral hernia (abdominal wall muscles weaken, allowing organs or tissues to bulge through) with obstruction (blockage), perforation of the intestine (hole that develops in the wall of the intestine causing the content to leak into the abdomen), peritonitis (swelling of the lining of the abdomen), and Type 2 Diabetes Mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 148 ' s History and Physical (H&P) Examination, dated 8/12/2024, the H&P indicated Resident 148 had capacity to understand and make decisions. During a review of Resident 148 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 11/15/2024, the MDS indicated Resident 148 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 148 ' s Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 11/27/2024, the PT Discharge Summary indicated Resident 148 walked 75 feet with supervision/standby assist (cueing, standby for safety) using a two-wheeled walker (an assistive device with two front wheels used for stability when walking). The PT Discharge Summary indicated Resident 148 was referred to a RNA Program. During a review of Resident 148 ' s physician orders, dated 11/28/2024, the physician orders indicated RNA for ambulation (the act of walking) with two-wheeled walker, three times per week as tolerated. During a review of Resident 148 ' s RNA Record for 2/2025, the RNA Record indicated Resident 148 was seen by RNA three times per week throughout the month. During an observation on 2/26/2025 at 10:38 AM with Resident 148 and Restorative Nursing Aide 1 (RNA 1), Resident 148 ' s RNA session was observed. Resident 148 was fully dressed and sitting at the edge of the bed. RNA 1 placed the two-wheeled walker in front of Resident 148 who stood without any physical assistance. Resident 148 walked out of the room, down the hallway, and returned to the room while RNA 1 followed Resident 148 with a wheelchair. During an interview on 2/26/2025 at 10:49 AM with Resident 148 and RNA 1, Resident 148 stated she did not feel well on Monday, 2/24/2025 and did not participate in RNA for walking. RNA 1 stated Resident 148 walked last week since she did not feel well on Monday, 2/24/2025. During a concurrent interview and record review on 2/26/2025 at 2:37 PM with RNA 1, Resident 148 ' s RNA Record for 2/2025 was reviewed. RNA 1 stated Resident 148 last walked with RNA 1 on Friday, 2/21/2025. RNA 1 stated Resident 148 did not participate in RNA on Monday, 2/24/2025 because Resident 148 was not feeling well. RNA 1 reviewed Resident 148 ' s RNA Record and stated RNA 1 ' s initials were entered for 2/24/2025. RNA 1 stated she should have circled the initials for 2/24/2025 to indicate Resident 148 refused to participate. RNA 1 stated she should have but did not document Resident 148 ' s reason for refusal on the back of the RNA Record. RNA 1 stated Resident 148 ' s RNA Record for 2/24/2025 was inaccurate. During an interview on 2/28/2025 at 7:58 PM with the Director of Staff Development (DSD), the DSD stated the RNAs were not supposed to initial or were supposed to circle their initials on the RNA Record when a resident refused treatment. The DSD stated it was not appropriate to initial the RNA record if the treatment was not provided. The DSD stated Resident 148 ' s RNA Record for 2/24/2025 was inaccurate. 47467 2. During a review of Resident 180's Admission Record (AR), the AR indicated the facility admitted Resident 180 on 1/29/2025 with diagnoses that included pneumonia (a severe an infection of the lungs that may be caused by bacteria, viruses, or fungi), sepsis (a life threatening infection in the blood which could lead to decreased in blood pressure (BP), increased heart rate (HR), shortness of breath and altered level of consciousness, that can damage the body organs). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 180 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated 2/4/2025, indicated Resident 180 ' s cognition (ability to think, remember, and reason with no difficulty) was intact and needed partial assistance (helper does less than half the effort) in eating and personal hygiene. During a review of Resident 180 ' s Laboratory Results Report, dated 2/23/2025 timed at 11:48 PM, indicated Resident 180 had critical lab values for blood glucose (BG, the amount of sugar in the blood) level of 60 milligrams (unit of weight) per deciliter (a metric unit of capacity) (mg/dL- reference range 65-99 mg/dL) and [NAME] Blood Count (WBC) count of 39.59 cells per microliter (unit of volume) of blood (normal reference range was 4-11 cells per microliter of blood). During a review of Resident 180 ' s Change in Condition (CIC) Evaluation, dated 2/24/2025, indicated Resident 180 had critical lab results with low glucose of 60, high WBC of 39.59 with no fever, clear breath sounds, and vital signs within normal range. The CIC indicated, on 2/24/2025 at 2:48 AM, LVN 5 notified Resident 180 ' s Nurse Practitioner (NP) 1 about critical lab results of low blood glucose and high WBC and received a physician order for antibiotics (medication given to treat infection). During a review of Resident 180 ' s Progress Notes, dated 2/25/2025, created by LVN 5, indicated on 2/25/2025 at 8:45 AM, LVN 5 called NP 1 due to abnormal labs as of 2/23/2025 with no answer. The note indicated, on 2/25/2025 at 9:30 AM, LVN 5 had a follow up call and obtained order for IV antibiotics. During a review of Resident 180 ' s phone orders, dated 2/25/2025, Resident 180 had a physician order on 2/25/2025 at 10:14 AM for Zosyn (medication to treat infection) intravenously (into the vein/bloodstream) three times a day for Leukocytosis (an abnormally high number of white blood cells in the bloodstream) for 10 Days. During a review of LVN 5 ' s Employee Timecards, indicated LVN 5 did not work on 2/23/2025 and 2/24/2025. During a concurrent record review and interview on 2/25/2025 at 1:05 PM with LVN 5, Resident 180's CIC Evaluation, dated 2/24/2025, timed at 3:31 AM was reviewed. LVN 5 stated, she worked as a Desk Nurse during the day, who was responsible to assist the Charge Nurses in communicating with the doctors. LVN 5 stated, she only worked dayshift and was not working at nighttime on 2/23/2025 and 2/24/2025. LVN 5 stated, in the morning of 2/25/2025, she noticed that there was an incomplete CIC which was created on 2/24/2025 at 3:31 AM for critical lab results of low glucose and high WBC. LVN 5 stated, the CIC indicated that on 2/24/2025 at 2:28 AM, Resident 180 ' s physician was messaged and was still waiting for response, so she called Resident 180 ' s covering physician (NP 1) to report the critical lab results and received a physician order for antibiotics around 9:30 AM. LVN 5 stated, on 2/25/2025, after she received order for antibiotics, she revised the physician recommendations on 2/24/2025 at 2:48 AM from waiting for response to NP 1 made aware with new orders for IV antibiotic. LVN 5 stated, she forgot to change the physician notification time from 2/24/2025 at 2:48 AM to 2/25/2025 at 9:30 AM. LVN 5 stated, she should have documented her physician notification in Resident 180 ' s progress notes or a follow up assessment for the CIC to ensure accurate documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 4:20 PM with NP 1, NP 1 stated he was not notified of the critical lab results on 2/24/2025 at 2:48 AM. NP 1 stated, he received a call in the morning of 2/25/2025 and was informed by LVN 5 about the critical lab results so he ordered IV antibiotics. During an interview on 2/28/2025 at 4:44 PM with the Acting Director of Nursing (ADON), the ADON stated, it was the facility ' s responsibility to ensure accurate residents ' medical record. The ADON stated, LVN 5 should not revise any CIC created by a different LVN. The ADON stated, the resident ' s medical record must contain accurate information of what actually happened with the correct date and time. During a review of the facility ' s Policy and Procedure (P&P) titled, Guidelines for Charting and Documentation, revised 2012, the P&P indicated charting, and documentation must be concise, accurate, and complete. During a review of the facility ' s P&P titled, Nursing Documentation, dated 6/27/2022, 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. All patient information will be documented and entered in the appropriate section of the clinal record following established guidelines.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46779 Based on interview and record review, the facility ' s Quality Assessment and Assurance (QAA) committee failed to develop a Quality Assurance Performance Improvement (QAPI-a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve quality in nursing homes) to maintain an effective system to identify, monitor and evaluate implement the facility ' s plan to address care areas of concern that were substantiated during the previous year recertification survey, complaint and facility reported incident (FRI) during the period from 3/2024 to 3/2025 in accordance with the professional standards of practice, physician's orders and facility ' s policy and procedures. The deficient practices previously substantiated were under quality of care for the following Federal tags- F686 (prevention of pressure ulcer), F684 (quality of care), F689 (accidents and supervision) and F755 (pharmacy services- medication administration) The facility failed to: 1. Develop a QAPI plan on how ensure residents with significant change in condition were assessed, monitored, intervention provided, evaluated and reported to the physician immediately. 2. Evaluate the QAPI plan to ensure residents who were admitted to the facility without pressure ulcer (a skin breakdown due to prolonged unrelieved pressure or friction in the bony part of the body) does not develop new or worsened pressure ulcer and MASD (Moisture-Associated Skin Damage is an inflammation, irritation, skin breakdown characterized by redness, shininess, and feelings of burning, itching or pain, especially in areas exposed to moisture). 3. Develop a QAPI plan on how to ensure the medications was administered as ordered by the physician and in accordance with professional standard of practice to prevent medication errors. 4. Did not develop a QAPI plan to ensure competency check and performance evaluation for some of the facility ' s nursing staff and verified the competency of the registry nursing staff to ensure that the registry nursing staff were competent of caring for the residents in the facility. As a result of these deficient practices the facility continued to have deficient practices under substandard quality of care and does not meet the care and treatments needed by the residents which results in the resident ' s hospitalization and decline in wellbeing. Cross reference: F684, F686, F690, F725, F759, and F760. Findings: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an interview on 2/28/2025 at 6:25 PM with the Administrator (ADM), the ADM stated the QAA committee had not developed a QAPI plan to ensure the nursing staff were competent of delivering care to the residents, including assessing residents accurately, recognize and report change of condition, and administering medications. The ADM stated it was important that the nursing staff were competent to care for the residents to ensure quality of care and safety of the residents. 2. During a concurrent interview and record review on 2/28/2025 at 6:30 PM with the Administrator (ADM), System Improvement, Implementation and Re-evaluation on Skin and Wound Management, dated as the starting date on 2/10/2025, was reviewed. The ADM stated they had been doing 24-hour communication and daily audits of the skin and wound issue by the DON from Mondays to Fridays, and the weekly interdisciplinary team meeting to review the physician orders and status of the skin and wounds for each resident who had a skin issue or a wound. The ADM stated she had a list of residents that were having a skin issue or a wound. The ADM stated if they found a change of condition, they would report to the MD, get an order and revise the care plan. The ADM stated she thought they have been doing well on following up with each resident ' s skin and wound status, but she did not know why they did not identify the missed weekly skin/wound assessment and the new changes or worsened of the skin condition and wound for some residents which should had been evaluated. 3. During a concurrent interview and record review on 2/28/2025 at 6:25 PM with the Regional Clinical Resource (RCR), System Improvement, Implementation and Re-evaluation on Medication Management, dated as the starting date on 12/1/2024, was reviewed. The facility did not have a written QAPI plan to ensure that residents received medications as ordered by the physician or ensure residents were free of medication error. 4. During an interview on 2/28/2025 at 6:25 PM with the Administrator (ADM), the ADM stated the QAA committee was aware that the facility had not conducted the competency check and performance evaluation for some of the facility ' s nursing staff. The ADM stated the facility did not have a competency checklist for the registry nursing staff to ensure that the registry nursing staff were competent of caring for the residents in the facility. During a review of the facility ' s policy and procedure (P&P) titled, Quality Assurance and Performance Improvement Plan, revised on 4/2014, the P&P indicated This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems, and the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services; 2. Reinforce and build upon effective systems and processes related to the delivery of quality care and services; 3. Provide structure and processes to correct identified quality and/or safety deficiencies; 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; 5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; 6. Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility; and 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 During observation, interview, and record review, the facility failed to implement infection control practices as indicated in the facility ' s policy and procedure titled Infection Prevention and Control Program for four of nine residents (Residents 14, 166, 54 and 63) by failing to: 1. For Residents 14 and 166, the Treatment Nurse (TXN) 4 and TXN 5 provided wound care treatments to the residents with pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) without performing hand hygiene. 2. For Resident 54, and 63 who had a physician order for oxygen use by failing to ensure the nasal cannula (NC- a tube with small opening used to deliver oxygen to the nares) was labeled of when the NC was first used and when to be changed or discarded was on the floor. These deficient practices had the potential to result of cross contamination of disease-causing organisms that could result in infection for Resident 54 and 63 at increased risk for lung infection and for Resident 14 and Resident 166 to develop infection to their open pressure ulcers which may result in sepsis (a life-threatening blood infection) and lead to hospitalization . Findings: 1a. During a review of Resident 14 ' s Admission Record, the facility admitted Resident 14 on 1/19/2022 and readmitted on [DATE] with diagnoses of Chronic Respiratory Failure (long term condition where the lungs cannot get enough oxygen), neuromuscular dysfunction of bladder (damage to the nerves that control the bladder), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness that affected one side of the body) following cerebral infarction (stroke, that occurred when blood flow to the brain was blocked) affecting the right dominant side. During a review of Resident 14 ' s H&P dated 10/31/2022, Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14 ' s MDS, dated [DATE], the MDS indicated Resident 14 rarely made decisions regarding tasks for daily life. The MDS indicated Resident 14 was dependent (helper does all the effort) on staff for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as toileting and was dependent on staff to assist in turning from his back to his left or right side and turning to lie on his back on the bed. The MDS indicated Resident 14 had a suprapubic (a thin tube that drains urine from the bladder directly through the abdominal wall) indwelling catheter (a tube that drains urine from the bladder) and was always incontinent (loss of control) of bowel. The MDS indicated Resident 14 had one Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) upon admission. The MDS indicated Resident 14 ' s pressure ulcer treatment included pressure ulcer care and application of medications to the site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review Resident 14 ' s Order Summary Report (physician orders), dated 2/12/2025, the order indicated to clean Resident 14 ' s sacrococcyx (tailbone) extending to bilateral buttocks pressure ulcer with normal saline, pat dry, apply Santyl ointment (ointment to remove dead tissue from wounds) cover with calcium alginate (material in wound dressings to absorb excess fluids from wounds) then cover with silicone foam dressing every day shift for 21 days. During a review of Resident 14 ' s Order Summary Report, order start date of 2/19/2025, the order indicated to clean Resident 14 ' s right gluteal fold pressure ulcer with normal saline, pat dry, and apply collagen sheet(a think flexible sheet, made from collagen protein that was applied directly to the pressure ulcer to help it heal faster) cover with foam dressing every day. During a review of Resident 14 ' s care plans, date initiated 8/23/2024, the care plan indicated Resident 14 was on enhanced barrier precautions (EBP, infection control measures with the use of personal protective equipment [PPE, clothing or equipment to protect from hazardous materials] to prevent the spread of multi-drug-resistant organisms [MDRO, bacteria resistant to more than one antibiotic]) to reduce the transmission of MDRDO. The care plans interventions included staff using proper PPE such as gloves, masks, and gowns and to do proper hand hygiene before and after resident care. During an observation on 2/28/2025 at 9:57AM with Treatment Nurse (TXN) 5, in Resident 14 ' s room, Resident 14 ' s right gluteal fold pressure ulcer wound care treatment was observed. TXN 5 was wearing clean gloves, touched Resident 14 ' s privacy curtains, then proceeded to perform Resident 14 ' s wound care treatments without changing gloves or performing hand hygiene. 1b. During a review of Resident 166 ' s Admission Records, the facility admitted Resident 166 on 12/10/2024 and readmitted on 1/13/2025 with diagnosis that included metabolic encephalopathy (disorder that occurred due to an imbalance of chemicals in the blood), sepsis due to anaerobes (bacteria), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in bloods sugar control and poor wound healing). During a review of Resident 166 ' s H&P, Resident 166 ' s H&P indicated Resident 166 did not have the capacity to understand and make decisions. During a review of Resident 166 ' s MDS, dated [DATE], indicated Resident 166 never made decisions regarding tasks of daily life. The MDS indicated Resident 166 was dependent (Helper does all the effort) on staff for all ADLs and was dependent on staff to turn Resident 166 from his back to his left or right side and to return lying on his back on the bed. The MDS indicated Resident 166 had an indwelling catheter (a tube that drains urine from the bladder) and was always incontinent (loss of control) of bowel. The MDS indicated Resident 166 had 1 Stage 4 Pressure Ulcer upon admission and had 3 unstageable pressure ulcers (a pressure ulcer covered with dead tissue where the stage is not clearly defined) upon admission. The MDS indicated Resident 166 had surgical wounds. The MDS indicated the skin ulcer/injury treatments included pressure ulcer care, applications of nonsurgical dressing, and application of dressings to feet. During an observation on 2/28/2025 at 10:33AM with TXN 4, in Resident 166 ' s room, Resident 166 ' s wound care treatments were observed. TXN 4 was wearing clean gloves, touch Resident 166 ' s privacy curtains and the window curtain ' s beaded chain to lower the window blinds, then proceeded to perform Resident 14 ' s wound care treatments without changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/28/2025 at 11:30M with Registered Nurse (RN) 3, RN 3 stated all wound care treatments should begin with clean gloves and clean gloves should be changed between dirty and clean dressing changes and in-between different wound sites. RN 3 stated, there could be bacteria or viruses on the privacy curtains or beaded chain that may be transferred to the resident ' s open pressure ulcer, which could lead to infection of the pressure ulcer. During an interview on 2/28/2025 at 5:38PM with RN 1, RN 1 stated if the TXN touched a resident ' s environment with clean gloves, the TXN must change their gloves and wash their hands before performing the actual treatment. RN 1 stated, it was important to change gloves and wash their hands to prevent the spread of infection especially for an open wound. During a review of the facility ' s policies and procedures (P&P), titled Infection Prevention and Control Program, dated 9/18/2023, the P&P indicated to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. During a review of the facility ' s P&P, titled Infection Prevention and Control Program, dated 9/18/2023, the P&P indicated important facets of infection prevention include . educating staff and ensuring that they adhere to proper techniques and procedures. 47467 2. During a review of Resident 54's Admission Record (AR), the AR indicated Resident 54 was initially admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses that included bronchopneumonia (a type of pneumonia [an infection of one or both of the lungs caused by bacteria, viruses, or fungi]) that causes inflammation (a normal part of the body's response to infection) of the air tubes in the lungs]. During a review of Resident 54 ' s History and Physical Examination (HPE), dated 1/21/2025, indicated Resident 54 had fluctuating capacity to understand and make decision. During a review of Resident 54 ' s Minimal Data Set (MDS-a federally mandated resident assessment), dated 1/24/2025, indicated Resident 54 ' s cognition (ability to think, remember, and reason with no difficulty) was moderately impaired and needed set up or clean up assistance in eating and oral hygiene. During a review of Resident 54 ' s Order Summary Report (OSR), indicated on 2/25/2025, Resident 54 had a physician order for oxygen therapy via nasal cannula at 3 L/min [Litters (unit of volume) per minute (unit of time)] for shortness of breath (SOB) and to maintain oxygen saturation (measures how much oxygen blood carries in comparison to its full capacity) above 93% every 4 hours as needed. During a concurrent observation and interview on 2/25/2025 at 10:26 AM in Resident 54 ' s room, Resident 54 was observed lying in bed. At Resident 54 ' s bedside, an oxygen supplement device was observed on and connected with a NC that was on the floor. In addition, the NC was not dated with when the tube was first used and when to change the NC. Resident 54 stated, the nasal cannula was for oxygen use, and she did not know why it was on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/25/2025 at 10:28 AM in Resident 54 ' s room the Licensed Vocational Nurse 7. LVN 7 stated, Resident 54 ' s NC should be labeled with date when it was first used and when to change and discard the NC and the NC should not be on the floor when not in use. During a review of Resident 63's AR, the AR indicated Resident 63 was initially admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses that included pneumonia, chronic obstruction pulmonary disease (COPD - a lung disease characterized by long-term poor airflow) with acute exacerbation, and acute pulmonary edema (condition caused by excess fluid in the lungs). During a review of Resident 63 ' s HPE, dated 1/31/2025, indicated Resident 63 did not have the capacity to understand and make decision. During a review of Resident 63 ' s MDS, dated [DATE], indicated Resident 63 ' s cognition (ability to think, remember, and reason with no difficulty) was moderately impaired and needed moderate assistance (helper does less than half the effort) in personal hygiene. During a review of Resident 63 ' s OSR, indicated on 1/29/2025, Resident 63 had a physician order to administer oxygen at 2 L/min via nasal cannula as needed for SOB every 8 hours as needed. During a review of Resident 63 ' s care plan for respiratory complications related to asthma, COPD, pneumonia, dated 1/29/2025, indicated the interventions was to administer oxygen as ordered via NC. During a concurrent observation and interview on 2/25/2025 at 10:51 AM with Resident 63, Resident 63 was observed sitting in bed with NC on the floor that was not labeled with when the NC was first used and when to change or discard. Resident 63 stated, she could not recall when she last needed oxygen supplement via the nasal cannula. During an interview on 2/25/2025 at 11 AM with LVN 7, LVN 7 stated she was not aware that Resident 63 had a physician order for oxygen therapy as needed so she did not check on the resident ' s oxygen supplement device and was not aware that the resident ' s nasal cannula was on the floor when she made her round at 7 AM. During an interview on 2/28/2025 at 4:29 PM with the Acting Director of Nursing (ADON), the ADON stated, it was important for the licensed nurses to check on their residents who had oxygen use to check if they needed oxygen therapy. The ADON stated, if the residents did not need their oxygen supplement, the licensed nurses were responsible to make sure the nasal cannula was stored appropriately to prevent infection. The ADON stated, all nasal cannula needed to be labeled with open date so that the licensed nurses would be aware how long the nasal cannula was used and if it was changed weekly. The ADON stated, not labeling the nasal cannula and having the nasal cannula on the floor put the resident at risk for lung infection. During a review of the facility ' s Policy and Procedures (P&P) titled, Oxygen Administration, undated, indicated oxygen therapy is administered by way of an oxygen nasal cannula. The nasal cannula is a tube that is placed approximately one-half inch into the resident ' s nose, it is held in place by an elastic band place around the resident ' s head. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled, Infection Control Program, dated, indicated important facets of infection prevention include identifying possible infections, instituting measures to avoid complications or dissemination

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation, interview, and record review, the facility failed to ensure three of three sampled residents (Resident 138, 110, and 166) bedframes and mattresses gaps were compatible and identified areas for possible bed entrapment (when a resident becomes trapped in a hospital bed, usually in the space between the mattress and the bedrail [the metal or plastic bars along the side of the bed]). This failure had the potential to result in Residents 138, 110, and 166 becoming entrapped between the bedframe and the mattresses gaps and may result in serious injuries such as cuts, bruises, pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) or even death. Findings. 1. During a review of Resident 138's Admission Record, the facility admitted Resident 138 on 5/31/2024 and readmitted Resident 138 on 10/16/2024 with diagnoses of quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), muscle weakness, and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 138's Minimal Data Set (MDS, a resident assessment tool), dated 12/2/2024, the MDS indicated Resident 138 never/rarely made any decisions regarding the tasks of daily life. The MDS indicated Resident 138 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and was dependent on staff to assist him turning him from his back to his left or right side and returning to his back on the bed. During a review of Resident 138's Bed Rail Evaluation, dated 10/16/2024 and 1/16/2025, the Bed Rail Evaluation indicated there was no gap between the headboard or the footboard and the mattress. During an observation on 2/25/2025 at 10:30AM in Resident 138's room, Resident 138's head of bed elevated to less than 30 degrees (the resident's upper body higher than the feet) and foot of bed were slightly elevated less than 30 degrees (the resident's lower legs slightly higher than the upper body) with a large gap noted in between the footboard (board at the end of the bed) and the mattress, big enough Resident 138's left drop foot boot (a brace that supports the foot and ankle) was noted in-between the mattress and the footboard. During another observation on 2/28/2025 at 9 AM in Resident 138's room, Resident 138's head of bed and foot of bed were slightly elevated to less than 30 degrees with a large gap noted in-between the footboard and the mattress. (continued on next page)

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	056487	A. Building B. Wing	03/01/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/28/2025 at 1:35PM with the Maintenance Department Director (MDD), the MDD stated, he tests the bedrails by doing an entrapment assessment with the bed flat and not when the bed is elevated. The MDD stated he only tested the four side rails on the side of the bed. The MDD stated, he did not test the gap between the head of the bed and the mattress or the gap between the footboard and the mattress. The MDD stated, he only observed the foot and the head of the bed if there was a gap. During an observation on 2/28/2025 at 2 PM with the MDD and Registered Nurse (RN) 3 in Resident 138's room, MDD stated there was gap between the mattress and the footboard. During a concurrent observation and interview on 2/28/2025 at 2:05PM with RN 3 in the presence of MDD inside Resident 138's room, Resident 138's bed and mattress was observed with a gap between the mattress and the footboard. RN 3 stated, Resident 138's head of bed was usually elevated and usually had a large gap in between the footboard and the mattress while the Resident 138 was in bed. 2. During a review of Resident 110's Admission Record, the facility admitted Resident 110 on 10/12/2022 and readmitted Resident 110 on 2/28/2024 with diagnoses that included functional quadriplegia, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or muscle weakness that affects one side of the body) following cerebral infarction (type of stroke that occurred when blood flow to the brain was blocked) affecting right dominant side, and contractures (a stiffening/shortening at any joint, that reduces the joint range of motion) of an unspecified joint. During a review of Resident 110's H&P, dated 3/9/2024, the H&P indicated Resident 110 had the capacity to understand and make decisions. During a review of Resident 110's MDS, dated [DATE], indicated the resident never/rarely made any decisions regarding the tasks of daily life. The MDS indicated Resident 110 was dependent on staff for all ADLs and to assist him in turning from his back to his left or right side and returning to his back on the bed. During an observation on 2/25/2025 at 10:40AM in Resident 110's room, Resident 110's head of bed and foot of bed were slightly elevated less than 30 degrees with a large gap noted in between the footboard and the mattress, and a pillow was noted in-between the mattress and the footboard. During a review of Resident 110's Bed Rail Evaluation, dated 2/28/2024, the Bed Rail Evaluation indicated there was no gap between the head or foot board and mattress. The was no documented evidence that the Resident 110's footboard and mattress was reassessed for gaps to prevent entrapment since 2/28/24 (one year ago). During an observation and interview 2/25/2025 at 6 PM in Resident 110's room with Family Member (FM) 4, FM 4 stated Resident 110's and Resident 138's bed always had the gap in between the mattress and the footboard since Resident 110 had been in this facility. During another observation on 2/28/2025 at 9AM in Resident 110's room, Resident 110's head of bed and foot of bed were slightly elevated to less than 30 degrees with a large gap noted in-between the footboard and the mattress. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another concurrent observation and interview on 2/28/2025 at 2PM with RN 3 in Resident 110's room, Resident 110's bed and mattress was observed. RN 3 stated, there was a large gap in between the footboard and the mattress while Resident 110 was in bed. 3. During a review of Resident 166's Admission Record, the facility admitted Resident 166 on 12/10/2024 and readmitted Resident 166 on 1/13/2025 with diagnoses that included contracture of the left knee, contracture of the right knee, nontraumatic chronic subdural hemorrhage (buildup of blood between the brain and its outermost covering), and muscle weakness. During a review of Resident 166's H&P, the H&P indicated Resident 166 did not have the capacity to understand and make decisions. During a review of Resident 166's MDS, the MDS indicated Resident 166's cognitive status was not documented and never/rarely made decisions regarding the tasks of daily life. The MDS indicated Resident 166 was dependent on staff for ADLs and dependent on staff to help him roll from his back to his left or right side and to return to lying on his back. During a review of Resident 166's Bed Rail Evaluation, dated 12/4/2024 and 1/13/2025, indicated there was no gap between the head or footboard and the mattress. During an observation on 2/25/2025 at 3PM in Resident 166's room, Resident 166's head of bed and foot of bed were slightly elevated less than 30 degrees with a large gap noted in-between the footboard and the mattress, big enough Resident 166's pillow and linens were noted in-between the mattress and the footboard. During another observation on 2/28/2025 at 11AM in Resident 166's room, Resident 166's head of bed and foot of bed were slightly elevated to less than 30 degrees. There was a large gap noted in-between the footboard and the mattress. During another concurrent observation and interview on 2/28/2025 at 2:15PM with RN 3 in Resident 166's room, Resident 166's bed and mattress was observed. RN 3 stated, there was a large gap in between the footboard and the mattress while Resident 166 was in bed. During an interview on 2/28/2025 at 6PM with RN 1 and the Acting Director of Nursing (ADON), RN 1 stated, there should not be a gap between the headboard and the mattress or the footboard and the mattress. During an interview on 2/28/2025 at 6:05PM with RN 1 and the ADON, the ADON, a large gap could lead to entrapment. The Acting Director of Nursing stated, a resident's body part could be trapped between the bedrail and the mattress or the bedframe and the mattress, which could lead to injury such as a fracture or even death if the Resident's neck was caught in between the gap between the mattress and the bedframe or bedrail. During a review of the facility's policies and procedures (P&P), titled Bed Safety, dated 3/22/2022, the P&P indicated, the facility will provide a properly working bed, and a properly fitting mattress and/or side rails to reduce the hazards of resident entrapment. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review the facility's P&P, titled Bed Safety, dated 3/22/2022, the P&P indicated to ensure that no gap exists between the mattress, bedframe, or side rail is wide enough to entrap a resident's head, body, arm, or legs. During a review of the facility's P&P, titled 'Bed Safety, dated 3/22/2022, the P&P indicated to ensure that replacement mattresses and bed rails are suitable with the dimensions of the bed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to maintain three of four residents sampled (Resident 126, 159 and 171) call light (device used by the resident to communicate needs) in functional and operating condition. This deficient practice had the potential for unmet resident ' s needs and calls for assistance that, may cause negative outcomes such as accidents/injury and/or anxiety (fear of the unknow) and depression (a severe feeling of hopelessness and sadness). Findings: 1. During a review of Resident 126 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), fatty liver (a condition where excessive fat accumulates in the liver) During a review of Resident 126 ' s History and Physical [H&P] dated 1/16/2025, the H&P indicated the resident has fluctuating capacity to understand and make decisions. During a review of Resident 126 ' s Risk for falls revised on 9/02/2024 with a goal indicating the resident will have no falls with injury for 90 days included an intervention to place the call light within reach while I bed or close proximity to the bed, remind resident to use call light when attempting to ambulate or transfer. 2. During a review of Resident 159 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission to the facility on [DATE] with diagnoses that included Type 2 Diabetes mellitus (a condition in which the body has problems controlling sugar in the blood), Unspecified visual loss (loss of the ability to see well). During a review of Resident 159 ' s History and Physical [H&P] dated 10/30/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 159 ' s Risk for Falls revised on 11/15/2024 with a goal that a resident will remain free from falls and injuries. The interventions included intervention to place the call light within reach while I bed or close proximity to the bed, remind resident to use call light when attempting to ambulate or transfer. 3. During a review of Resident 171 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included absence of right leg below the knee(missing right lower leg below the knee), absence of left leg below the knee (missing left lower leg below the knee) During a review of Resident 171 ' s History and Physical [H&P] dated 2/06/2025, the H&P indicated the resident has the capacity to understand and make decisions. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 171 ' s Risk for Fall care due to impaired mobility revised on 2/10/2025 with a goal to have less injuries related to fall by next review. The interventions included intervention to place the call light within reach while I bed or close proximity to the bed, remind resident to use call light when attempting to ambulate or transfer. During a concurrent observation and interview with Resident 171, inside Resident 126 ,159 and 171 ' s room, on 2/26/2025 at 10:24 AM, Resident 171 ' s call light was observed in Resident 171 ' s hand. Resident 171 ' s call light was observed plugged into the wall. Resident 171 stated he had pressed the call light over and over for a while and no one had come to as he wanted a snack because he was hungry. During a concurrent observation and interview on 2/26/2025 at 10:42 AM with Certified Nursing Assistant (CNA 14). The CNA 14 checked the call light and confirmed the call light does not turn on the light outside the room to indicate Resident 171 ' s call lights had been pressed. CNA was observed pressing the call lights for Residents 126 and 159 in the room and checked outside and verified the light was not turning on outside the resident room to indicate the call lights had been pressed for all three residents' beds. CNA 14 stated she would notify Charge nurse and Maintenance department to fix the light bulb outside the room. During an observation and interview with Registered Nurse (RN 3) on 2/26/2025 at 6:15 PM, RN 3 was observed pressing Resident 171 ' s call light and checking outside the room confirming Resident 171 ' s call light did not light up outside to indicate it was pressed. RN 3 stated she was not aware the light outside the room was not working, RN 3 stated no one had communicated this issue to her before. RN 3 stated she will input a work order to the maintenance department to inform them of the issue. RN 3 stated it is important for the call light to be working for all residents so that the Residents can be able to communicate their needs to staff, and to prevent residents care needs from being met or missed because the call light is not working. During an interview with Maintenance Supervisor on 2/26/2025 at 6:18 PM, MS stated he was not aware the light bulb for Residents 126,159 and 171 ' s room was not working. MS was observed checking the call light by pressing Resident 126,159 and 171 ' s light and confirming the light bulb outside was not turning on to indicate the light was had been pressed. MS stated if he was made aware by nursing staff he would have replaced. During a review of the facility ' s policy and procedure (P&P) titled Maintenance Service dated with a revised date of December 2009, indicated The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .g. maintaining the paging system in good working order.