

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Rio Hondo Subacute & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 273 E Beverly Boulevard Montebello, CA 90640	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to obtain and maintain a complete informed consent for the use of psychotropic medications (medication that affects mood and behavior) for three of three sampled Residents (Resident 1, Resident 2, 13, 16 and Resident 106) prior to administration in accordance with the facility's policies titled Psychotropic Medication Use - Quality of Care and Psychotropic Medication Use, which require obtaining and verifying informed consent prior to the administration of psychotropic medications. The facility failed to ensure: 1. Resident 1's records lacked informed consent for divalproex (Depakote, a prescription medication used to control seizures) (administered from 2/1/2026 to 2/10/2026) and trazodone HCL (a prescription medication primarily used to treat depression) (administered from 2/1/2026 to 2/10/2026), and the consent for Ativan (anti-anxiety medication) (administered from 2/1/2026 to 2/10/2026) was incomplete. 2. Resident 2, who had no capacity to speak and make decisions, the informed consent for Quetiapine Fumarate (a psychotropic medication that is used to manage behaviors) was not obtained from the responsible party or representative. 3. For Resident 106 who had no capacity to make medical decisions, the informed consent for Imipramine (a medication used to treat depression) 25 milligrams (mg- a unit of measurement) was not signed by Resident 106's representative. 4. For Resident 16, ensure informed consent was obtained for the resident who was receiving Escitalopram (medication used to treat depression) and Seroquel (medication used to treat schizophrenia), limiting the resident's ability to participate meaningfully in their care. 5. For Resident 13, ensure informed consent was obtained for the resident who was receiving Risperdal (medication used to treat schizophrenia), Trazadone (antidepressant primarily used to treat major depressive disorder), and Buspirone (medication used to treat generalized anxiety disorder and relieve short-term symptoms of anxiety) limiting the resident's ability to participate meaningfully in their care. These deficient practices placed Resident 1, Resident 2, Resident 13, Resident 16 and Resident 106 at risk of receiving medications without their or their responsible party's agreement, knowledge of potential adverse effects, and it is a violation of residents' rights while residing in the facility.^^ Findings: During a review of the facility's undated policy and procedure (P&P) titled Psychotropic Medication Use & Quality of Care, the policy indicated that prior to initiating, increasing the dose of, or switching to a different psychotropic medication, staff and the physician will review the following with the resident or representative before obtaining documented consent or refusal: non-pharmacological alternatives; the indications and rationale for the recommendation; the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and the resident's or representative's right to accept or decline the treatment. Additionally, during a review of the facility's policy and procedure titled Psychotropic Medication Use, dated June 2021, the policy indicated that it is the responsibility of the attending health care (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Comprehensive Medical Chart, it was noted that the chart did not contain a Psychotropic Medication Administration Disclosure/Informed Consent Form for the medication's divalproex (administered from 2/1/2026 to 2/10/2026) and trazodone (administered from 2/1/2026 to 2/10/2026). This failure is not in accordance with the facility's policies, which require obtaining and verifying informed consent prior to the administration of psychotropic medications. During an interview on 2/9/2026 at 3:09 PM, Licensed Vocational Nurse (LVN) 8 stated there was no consent form for trazodone and divalproex, but there should have been so the facility staff would have permission to administer the medications. LVN 8 further stated that without consent, there could be side effects from the medications that the facility staff were not monitoring. During a review of Resident 1's Ativan Consent Form on 2/9/2026 at 3:15 PM, LVN 8 stated the consent form was incomplete because it did not include the reason why the resident was prescribed the medication. LVN 8 added that this information is necessary to implement the resident's care plan and ensure the facility staff monitor the resident's medication use appropriately. During an interview on 2/9/2026 at 4:45 PM, the facility's Pharmacist Consultant (PC) stated there should have been a consent for Resident 1's medications—Ativan, trazodone, and divalproex—to ensure there was no abuse and that guidelines were being followed. The PC explained that these medications are often used to sedate residents, and ensuring that was not happening was important, especially given the resident's dementia diagnosis. The PC further stated that without a consent, the facility could not start the medication; otherwise, the facility would not be following federal regulations. During an interview on 2/10/2026 at 12:52 PM, the Director of Nursing (DON) 1 stated that informed consent for trazodone and divalproex should have been in the resident's chart or electronic system. DON 1 explained that without proper informed consent, facility staff could not administer those medications because they would not know if the resident agreed to the treatment. DON 1 further stated that without informed consent, the facility could be acting against the will of the resident, and emphasized that the resident has rights, so facility staff must obtain informed consent. During an interview on 2/10/2026 at 12:56 PM, the Director of Nursing (DON) 1 stated that the Ativan informed consent was incomplete but should have been complete. DON 1 explained that the consent form should have included the reason why the resident was prescribed the medication and the duration for which the resident was to receive the medication. 2. During a review of Resident 2's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dependence on respirator (a machine used to assist with breathing), dementia (a progressive brain disorder characterized by a decline in memory, language, problem-solving, and other cognitive functions), and aphasia (a neurological disorder that impairs the ability to speak, understand, read, and write). The AR also indicated that Family Member (FM) 4 is Resident 2's responsible party (the decision maker for the resident's care). During a review of Resident 2's psychiatry progress notes, dated 3/5/2025, the Notes indicated that Resident 2 was not verbally responsive. During a review of Resident 2's care plan for the use of Quetiapine Fumarate, initiated on 5/26/2025, (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Similarly, a review of Resident 16's Psychotropic Medication Administration Disclosure for the use of Escitalopram (an antidepressant), also dated 1/14/2025, revealed that no resident or resident representative signature was obtained, and no physician counter-signature was documented. During a concurrent interview and record review on 2/10/2026 at 1:22 PM, the Director of Nursing (DON 2) confirmed that Resident 16's Psychotropic Medication Administration Disclosures for Seroquel and Escitalopram, both dated 1/14/2025, were missing the resident or resident representative signature as well as the physician counter-signature. DON 2 stated that obtaining informed consent is essential because it demonstrates that the resident or family is aware of and agrees to the medications being administered. DON 2 further explained that the physician's signature verifies that the physician communicated with the resident or family regarding the medication. 4. During a review of Resident 13's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included bipolar disorder, depression, anxiety. During a review of Resident 13's History and Physical (H&P), dated 4/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 13's Order Summary Report indicated the following orders: On 12/29/2025, a physician order indicated Risperidone Oral Tablet 1 mg give 2 tablet by mouth at bedtime for bipolar disorder verbal outbursts, including yelling and raising voice On 12/30/2025, a physician order indicated Trazadone Hydrochloride (HCl) Oral Tablet 50 mg give 1 tablet by mouth at bedtime for depression manifested by inability to sleep +6 hours On 12/31/2025, a physician order indicated Buspirone Hydrochloride (HCl) Oral Tablet 5 mg give 1 tablet by mouth three times a day for anxiety manifested by increased need for redirection and reassurance during interactions. During a review of Resident 13's undated Psychotropic Medication Administration Disclosure (anti-psychotic) for the use of Risperdal indicated no Physician name or Physician signature and date obtained. The disclosure did not indicate resident's room number, medical record number, and physician. The disclosure During a review of Resident 16's Psychotropic Medication Administration Disclosure for the use of Trazodone (an antidepressant), dated 5/30/2025, it was noted that the physician's signature was missing. Similarly, a review of Resident 16's Psychotropic Medication Administration Disclosure for the use of Buspirone (an anti-anxiety medication), also dated 5/30/2025, revealed that the physician's signature was not obtained. During a concurrent interview and record review of Resident 16's Psychotropic Medication Administration Disclosures for Risperdal (undated), Trazadone, and Buspirone dated 5/30/2025 with the Director of Nursing (DON) 2 on 2/10/2026 at 1:22 PM, DON 2 stated the resident representative signature and physician signature was missing. DON 2 stated it was important for the informed consent to be completed because it shows that the resident/family was aware and being informed of what medication was being administered to the resident. DON 2 stated the physician signature (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verifies that the physician spoke to the resident's family. During a review of the facility's undated policy and procedure (P&P) titled Psychotropic Medication Use &dash; Quality of Care, the policy indicated that prior to initiating, increasing the dose of, or switching to a different psychotropic medication, staff and the physician will review the following with the resident or representative before obtaining documented consent or refusal: non-pharmacological alternatives; the indications and rationale for the recommendation; the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and the resident's or representative's right to accept or decline the treatment. Additionally, during a review of the facility's policy and procedure titled Psychotropic Medication Use, dated June 2021, the policy indicated that it is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the prescriber prior to initiation of the psychotropic medication, and the facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. 5.During a review of Resident 106's admission Record (AR), the AR indicated that Resident 106 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest.), Alzheimer's disease (a brain condition that slowly damages your memory, thinking, learning and organizing skills). During a review of Resident 106's History and Physical (H&P) signed and dated by Nurse Practitioner (NP) 1 on 1/12/2026, the H&P indicated the resident did not have the capacity to understand and make decision. During a review of Resident 106's Minimum Data Set (MDS), a federally mandated resident assessment tool, dated 1/12/2026, the MDS indicated the resident had severe cognitive impairment (problems with the ability to think, learn, remember, use judgment, and make decisions). The MDS further indicated the resident's active diagnoses included Alzheimer's disease and depression. Additionally, the MDS documented that the resident was receiving antidepressant medications. During a review of Resident 1's Psychiatric Consultation dated 01/15/2026, the consultation indicated Resident 106's primary language was Spanish, and staff assistance was obtained for translation. The consultation indicated physician discussed benefits, risk, and side effects to report resident verbalized understanding of instruction and agreement with new orders, informed consent obtained. During a review of Resident 106's Order Summary Report indicated active orders as of 2/10/2026, the report indicated an order for Imipramine HCL tablet 25 mg, the order indicated to give 1 tablet by mouth at bedtime for depression manifested by inability to fall asleep +6 hours. During a review of Resident 106's Medication Administration Record (MAR) for the period of 1/01/2026 to 1/31/2026, it was noted that the MAR documented administration of the Imipramine HCL 25 mg tablet from 1/06/2026 through 1/31/2026. During a review of Resident 106's Medication Administration Record (MAR) for the period of 2/01/2026 to 2/28/2026, it was noted that the MAR documented administration of the Imipramine HCL 25 mg tablet from 2/01/2026 through 2/09/2026. (continued on next page)		

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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** Based on observation, interview, and record review, the facility failed to ensure that staff demonstrated that the needs of two out of three sampled residents (Residents 76 and 92) were accommodated when: 1. Resident 76's call light pad (a pressure sensitive device that residents use to call for help to the room) was observed not within reach of Resident 76's who is a quadriplegic (paralysis of all four limbs and the torso). 2. Resident 92's call system (a device used by the resident's to call for help by pressing a button) was accessible to the resident at all times by failing to provide a call light pad (a specialized, easy-to-press button designed for resident's with limited hand strength or dexterity) when the resident was unable to use a call light button and the call light was observed to be placed out of reach. This deficient practice had the potential to delay care to Resident 76 and 92 during times of need and emergencies. Findings: 1. During a review of Resident 76's admission Record (AR), the AR indicated that the resident was admitted originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (occurs when the lungs cannot adequately transfer oxygen to the blood), quadriplegia (he paralysis of all four limbs and the torso), tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to facilitate breathing when the airway is blocked, reduced, or requires long-term respirator support), and dependence on respirator. During a review of Resident 76's History and Physical (H&P), dated 12/15/2025, the H&P indicated that the resident does have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 11/29/2025, the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (helper does all the effort) on self-care activities such as oral hygiene, toileting, bathing, and moving in bed. During a review of Resident 76's physicians orders, dated 12/15/2025, the order indicated for staff to suction tracheal secretions every 2 hours as needed for excessive secretions. During a review of Resident 76's care plan for alteration in respiratory status, initiated on 12/16/2025, the care plan included interventions for staff to suction the resident's airway as needed. During an observation and interview on 2/2/2026 at 9:09 AM inside Resident 76's room, Resident 76 was observed lying in bed. Resident 76's call light pad was observed clipped to the bed's linen at the upper left corner of the resident's bed and away from the resident's reach. Resident 76 stated he cannot call for help verbally and he must use the call light pad to call for help. Resident 76 added that he cannot reach the call light pad because the call light pad is not next to his cheek. Resident 76 stated he needed help because he felt that he needed to be suctioned. During a concurrent observation and interview on 2/2/2026 at 9:14 AM with Certified Nursing Assistant (CNA) 4 inside Resident 76's room, CNA 4 stated that Resident 76's call light pad is clipped to the bed linen and not within reach of Resident 76's cheek. CNA 4 stated that it should be right next to the resident's cheek because that is how the resident is able to call staff for assistance or help. CNA 4 added that Resident 76 stated he needed the respiratory therapist (a healthcare professional (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that specializes in the treatment and care of residents who have trouble breathing) because he needed to be suctioned During an interview on 2/6/2026 at 3:17 PM with Licensed Vocational Nurse (LVN) 12, LVN 12 stated that Resident 76 has a diagnosis of quadriplegia, which means that the resident cannot move his arms or legs. LVN 12 stated that Resident 76 can only move his head and neck, which is a reason why the resident needs the call light pad next to his cheek. LVN 12 stated that Resident 76 uses the call light pad to call for help, such as whenever the resident requests to be suctioned or if there were an emergency. During a concurrent interview and record review on 2/6/2026 at 3:23 PM with LVN 12, Resident 76's care plans were reviewed. LVN 12 stated that the resident's care plans did not include a care plan that provided staff with instructions to place Resident 76's call light pad right next to his cheek. LVN 12 stated that there should be a care plan that specifically instructs staff on how to care for the resident. LVN 12 added that the care plans are instructions for staff on how to properly take care of residents. During an interview on 2/10/2026 at 1:21 PM with the Director of Nursing (DON) 2, DON 2 stated that call lights might be placed within the reach of the resident. DON 2 added that the term within reach is specific to each resident's functional capacity. DON 2 stated that if the resident requires that the call light is next to the resident's cheek, then the call light device must be placed next to the resident's cheek. DON 2 added that if a resident who requires respiratory care such as suctioning cannot call for help because of an unreachable call light, the resident can potentially experience respiratory distress. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, undated, the P&P indicated that residents have the right to resident and receive services in the facility with reasonable accommodation of their needs and preferences. The P&P indicated that staff are trained and expected to assist residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the resident's wishes such as arranging the call light, assistive devices so that they are in easy reach of the resident. During a review of the facility's P&P titled, Answering the Call Light, revised 10/24/2024, the P&P indicated that the purpose of facility's P&P is to ensure timely responses to the resident's requests and needs. The P&P also indicates that staff are to ensure that the call light is accessible to the resident when in bed. 2. During a review of Resident 92's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included hemiplegia (one-sided muscle paralysis or weakness) and hemiparesis (a neurological condition characterized by weakness of reduced motor function on one side of the body often affecting the arm, leg, and face) of left non-dominant side, left hand contracture (a permanent tightening or shortening of muscles, tendons, skin, or other tissues that caused joints to become stiff, deformed, and limited in movement), and reduced mobility. During a review of Resident 92's History & Physical (H&P) dated 10/3/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 92's Occupational Therapy (OT) Evaluation dated 10/6/2025, the OT Evaluation indicated the resident was dependent (100% assist, or two or more helpers) for all (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	functional skills of activities of daily living (ADLs) with impaired right and left upper extremity (RUE & LUE) range of motion (ROM) that included the shoulder, elbow/forearm, and hand. The OT Evaluation indicated the resident's fine motor coordination and bilateral coordination were severe and coordination impairments/conditions impacting function included impaired alternating movements, impaired grasp/release of objects, impaired motor planning, impaired reach for objects, impaired object manipulation and impaired symmetrical movements. During a review of Resident 92's Minimum Data Set (MDS, a resident assessment tool) dated 12/1/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident was dependent (helper did all of the effort and the resident did none) on facility staff with all functional/self-care areas. During a review of Resident 92's Restorative Nursing Weekly/Monthly Progress Report dated 1/26/2026, the report indicated the resident received passive range of motion (PROM, a movement of a joint through range of motion by an outside force, without the person using their own muscles) for Resident 92's RUE and LUE. During a concurrent observation and interview in Resident 92's room on 2/2/2026 at 10:33 AM, Resident 92 was lying in bed, and the residents call light system was stuck in between the side rail, not in reach to the resident. Resident 92 stated she had a stroke (a brain attack that occurred when blood flow to part of the brain was blocked or a blood vessel burst) and was unable to move her arms or legs. Resident 92 stated she was unable to reach for the call light system or press the button. Resident 92's left and right hand were contracted (a condition where one or more fingers curl permanently toward the palm) with fingers curling inward toward the palm and elbows were in a bent position. During an interview on 2/28/2026 at 12:43 PM, Certified Nursing Assistant (CNA) 3 stated Resident 92 was fully dependent and was unable to move her arms because they were contracted and the resident's fists stayed close to her chest and did not move. CNA 3 stated if the call light was not within reach the resident could not call for help and the facility staff would not be able to assist Resident 92. During an interview on 2/10/2026 at 1:27 PM, Director of Nursing (DON) 1 stated if a resident was unable to press the call light system, the facility would replace the call light system with an appropriate system like a pad call light. DON 1 stated if a resident was unable to press the call light, the resident would not be able to express their needs, and the facility staff would not be able to tend to the resident. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light dated 10/24/2024, the P&P indicated The purpose of this procedure is to ensure timely responses to the resident's requests and needs. The P&P indicated general guidelines to follow: Ask the resident to return the demonstration and ensure that the call light is accessible to the resident when in bed. During a concurrent interview and record review of the facility's P&P on 2/2/2026 at 1:29 PM with DON 1, titled Accommodation of Needs dated November 2025 indicated, The resident has the right to reside and receive services in the facility with reasonable accommodation of their needs and preferences. The P&P indicated Staff are trained and expected to assist the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the resident's (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wishes. For example: arranging the call light, assistive devices, toiletries, and personal items so they are in easy reach of the resident. DON 1 stated the facility was not following the policy but should have been otherwise Resident 92 would not be able to facilitate her needs.		

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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** Based on interview and record review the facility failed to ensure four of five sampled residents (Resident 13, 14, 21, and 124) "Advance Directives Acknowledgement Form" (ADA-written statement of resident's medical treatment wishes) "was offered or obtained and "readily" accessible in the "resident's medical records. These "deficient practices" had the potential for residents' medical treatment wishes not be honored during emergencies or when incapacitated (the clinical state in which a patient is unable to "participate" in a meaningful way in medical decisions) and unable to participate in medical decision-making. Findings: During a review of the facility's policy and procedure (P&P) titled Advance Directive, dated 3/23/2022 indicated a copy of the Advance Directive is maintained as part of the resident's medical record. The P&P indicated if the resident has an Advance Directive, admission staff or designee will place a copy or scan of the Advance Directive in the resident's medical record and will notify the Director of Social Services of the existence of the Advance Directive. 1. During a review of Resident 13's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included unspecified fracture of upper end of right tibia, end stage renal disease (the final, permanent stage of chronic kidney disease, where kidneys function below 15% of normal capacity), unspecified asthma (condition that causes the airways to swell, narrow, and fill with mucus). During a review of Resident 13's History and Physical (H&P), dated 4/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 1/28/2026, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses)." During a review of Resident 13's Advance Health Care Directive Acknowledgment Form dated 4/1/2025, the Form indicated Resident 13 had an Advance Health Care Directive in place. During a review of Resident 13's Physician Orders for Life Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatment that can or cannot be done at the end-of-life) dated 4/18/2025, the POLST indicated the resident did not have an Advance Directive." During a concurrent interview and record review of Resident 13's Advance Health Care Directive Acknowledgment Form and POLST on 2/6/2026 at 4:22 PM, the Social Services Assistant (SSA) 1 stated Resident 13 had an Advance Directive, but Resident 1 did not provide the Advance Directive to the facility. SSA 1 stated there was no documentation of Resident 13's Advance Directive. During a concurrent interview and record review of Resident 13's Advance Health Care Directive Acknowledgment Form and POLST on 2/6/2026 at 4:24 pm, the Social Services Director (SSD) confirmed Resident 13 did not have an Advance Directive readily available at facility. The SSD stated (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the team had verbally followed up with Resident 13 and there has been no documentation of follow ups for Advance Directive. The SSD stated if Resident 13 had an Advance Directive it should have been followed up as soon as possible. The SSD stated the importance of having the Advance Directive in the chart was to know what the resident wishes were, and what care to provide to the Resident during a medical emergency. The SSD stated the Advance Health Care Directive Acknowledgment Form and POLST must be accurate, and both the documents must match. During an interview with the Director of Nursing (DON) 2 on 2/10/2026 at 2:11 PM, the DON 2 stated the Advance Directive was important to ensure the facility honors the resident and family's wishes. The DON stated during the admission process, facility staff would ask the resident or family if they have an Advance Directive. The DON stated if the resident had an Advance Directive, the facility staff would encourage the family to provide it as soon as possible. 2. During a review of Resident 14's admission Record (AR), the AR indicated that the facility originally admitted Resident 14 on 11/3/2025 with diagnoses including acute respiratory failure (failure of the lungs to meet the oxygen level in the blood), hypertension (high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool) dated 11/18/2025, the MDS indicated the Resident 14's cognition (thought process) was severely impaired (never/rarely made decision). During a review of Resident 14's Care Plan, dated 11/28/2025, the Care Plan indicated Resident 14 had impaired cognitive function and aphasia (a disorder that makes it difficult to speak). 3. During a review of Resident 21's AR, the AR indicated that the facility originally admitted Resident 21 on 10/15/2025 with diagnoses including post-laminectomy syndrome (any lingering pain of unknown origin following back surgery), spinal stenosis (the narrowing of one or more spaces within the spinal canal), and hypertension (high blood pressure). During a review of Resident 21's History and Physical Examination (H&P) signed by the attending physician on 10/16/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS & a resident assessment tool) dated 1/16/2026, the MDS indicated that Resident 21 had intact cognitive function (thought process or decision consistent/reasonable). 4. During a review of Resident 124's AR, the AR indicated that Resident 124 was originally admitted to the facility on [DATE] with diagnoses that included left femur fracture (broken thigh bone), anemia (a condition where the body does not have enough healthy red blood cells), and myocardial infarction (MI-heart attack) During a review of Resident 124's H&P dated 5/17/2025, the H&P indicated Resident 124 had the capacity to understand and make decisions. During a review of Resident 124's Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated the Resident 124's cognition was moderately impaired. (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 concurrent record review of Resident 14, 21, and 124's medical records on 2/4/2026 at 4 PM with the Registered Nurse (RN) 3, RN 3 stated there was no ADA forms on Resident 14, 21, and 124's hard copy of medical records or the residents' electronic health record (EHR). ^ During a concurrent interview^and record review^on 2/5/2026 at 11:25^AM with the Social Services Designee (SSD), the^SSD^stated^Resident 14, 21, and 124's ADA forms were still in their binder in the office but not^in^the resident's medical records' medical^records. The SSD stated that the ADA form should have been kept in the resident's medical record. During an interview on 2/9/2026 at 9:30^AM with the Director of Nursing (DON), DON stated that^the^advance directive^acknowledgement (ADA)^form^must^be readily accessible and placed in the^resident's^hard copy^medical records^in the event of an emergency so the licensed nurses^would^know^how to properly respond and^provide^the correct treatment in accordance with Resident 14, 21, and 124's^medical treatment wishes.^ ^ ^		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure that medications were securely stored, contained inside locked containers properly and disposed appropriately in according with facility's policies and procedures titled Medication Labeling and Storage The facility failed to: 1.Licensed Vocational Nurse (LVN) 6 left one of three sampled residents (Resident 96) medications such as Nitroglycerine (medication used to treat angina or chest pain, Midodrine (medication used to help increase blood pressure) and Depakote (medication used to prevent seizures) were left on top of the medication cart in the hallway unattended. 2. Ensure two of two Medication Carts (MC #1 and #2) were observed with had no pills and capsule on top of the waste container lid attached to the carts. These deficient practices had the potential for drug diversion (misuse of medication) and ingestion of medications that could cause residents clinically significant adverse reactions (undesired effect of medication). 3a.Ensure in Medication Cart #2 and #4 stored house supply medications; Docusate sodium (stool softener), Multivitamin with minerals and Senna (medication used to relieve constipation) were labeled with an opened date. 3b.Ensure in two of two MC (MC #2 and #4) stored residents medications with an opened date label: This deficient practice had the potential for residents not to receive full strength of the medications and ensure stability and efficacy of medications. Findings: 1.During a review of Resident 96's, admission Record (AR), dated [DATE], the AR indicated, Resident 96 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), cerebral Infarction (loss of blood flow to a part of the brain). During a review of Resident 96's Order Summary Report (OSR), dated [DATE] &ndash; [DATE] the OSR indicated that Resident 96 had prescribed the following medications: Depakote (medication used to treat seizure) affects tablet delayed released 500 mg (mg &ndash; metric unit of measurement, used for mediation dosage and/or amount) 1 tablet by mouth 3 times a day. Midodrine (medication used to increase blood pressure) 5 mg one tablet by mouth three times a day. Nitroglycerine (medication used to prevent attacks of chest pain -angina) medication used to treat 0.4 mg 1 sublingual tab, every 5 minutes for chest pain. During an observation on [DATE] at 4:14 Medication Cart for Station 2 was in the middle of the hallway with multiple medications including Midodrine 53 tablets, Depakote 48 tablets and a close bottle of Nitroglycerine tablets left on top of the cart without a staff present and the medications were accessible to unauthorized staff and residents. During an interview on [DATE] at 4:19 PM with LVN 6, LVN 6 stated she left the medication cart and went outside to the patio to talk to the Director of Nurses (DON) 1, but she forgot to put Resident 96's medications inside the drawer so the medications were left unattended. LVN 6 stated that when DON (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 called her, she thought it was going to be for a quick second and did not think that she was going to be gone for a while. During an interview on [DATE] at 5:35 PM with DON 1, DON 1 stated that medications should not be left unattended and should be locked inside the medication cart. During an interview on [DATE] at 5:48 PM with the Administrator (ADM) 2, ADM 2 stated, medications should have been stored in the medication cart and not been left on top of the medication cart. ADM 2 stated when medications aren't stored correctly, residents can get access to the medications and can place the residents at risk of adverse outcomes. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated medications are stored in an orderly manner in carts, locked when not in use and not left unattended if open or otherwise potentially available to others. 2. During an inspection of the facility's MC 1 on [DATE] at 10:24 AM, MC 1 contained a pharmaceutical waste container on the right side of MC 1. Upon inspection, the top of waste container lid had 2 white pills and 1 yellow-green capsule. The medications were visible and could be taken by hand. The medications were not secured inside of the waste bin. Two residents were observed wheeling around near the medication cart. During a concurrent observation and interview on [DATE] at 10:25 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that there are medications on top of the lid of MC 1's pharmaceutical waste container, and she does not know what medications they are and who they belong to. LVN 1 stated that the pills should not be there because they are easily accessible to residents and visitors. LVN 1 added that they must be inside the waste bin or secured inside of MC 1. LVN 1 further added that she is not certain if the medications are narcotics, or controlled substances. During another concurrent observation and interview on [DATE] at 10:26 AM with the Director of Nursing (DON) 2, MC 1 was observed and inspected. DON 2 stated that the medications on top of the MC 1's waste container must be secured and discarded properly. DON 2 added that she does not know if the medications are narcotics or controlled substances. DON 2 stated that she will have to remove the waste container and properly discard the medications. During an inspection of the facility's MC 2 on [DATE] at 10:29 AM, MC 2's pharmaceutical waste container on the cart was observed with 1 white pill on top of the waste bin's lid that was visible and could be taken by hand. During a concurrent observation and interview on [DATE] at 10:30 AM with LVN 4, LVN 4 stated that there is a white pill on top of MC 2's waste container lid. LVN 4 stated that the pill should be inside of the waste container and not on top of the lid. LVN 4 added that she does not know what medication is for and who it belongs to. During an interview on [DATE] at 1:21 PM with DON 2, DON 2 stated that nurses must ensure that discarded medications are inside of waste containers and not on top of the lid. DON 2 added that if the medications are not secured, residents and visitors can potentially take and ingest those medications, which could pose harm to the individuals. DON 2 further added that the medication carts must be kept clean and safe, which includes keeping medications inside the medication cart or throwing discarded medications inside of the waste container. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the facility's Policy and Procedure titled Medication Labeling and Storage on [DATE] at 1:21 PM with DON 2, DON 2 stated all medications must be inside locked compartments or containers including the medication carts. During a review of the facility's P&P titled, Medication Labeling and Storage, undated, the P&P indicated that the facility stores all medications and biologicals in locked compartments. The P&P indicated that nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The P&P also indicates that compartments containing medications and carts are not left potentially available to others. During a review of the facility's P&P titled, Disposal of Medications and Medication-Related Supplies, revised 1/2025, the P&P indicated that controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. The P&P indicated that the facility should secure controlled substances under double lock at all times. The P&P also indicated that double lock can mean a locked cabinet in a locked room or double locked cabinet. The P&P further indicated that only authorized licensed nursing and pharmacy personnel have access to controlled medications. 3. During a concurrent observation of medication pass and interview with Licensed Vocational Nurse (LVN) 5 on [DATE] at 9:26 AM, house supplies (over the counter medications that are not prescribed, wipes, bandages, gauze etc.) docusate sodium and multivitamin with minerals were observed without label indicating the opened date LVN 5 stated both medications look like it was opened yesterday, so I will put yesterday's date. During a concurrent observation of another medication pass and interview with LVN 5 on [DATE] at 9:35 AM, an opened house supply medication Senna was observed with no label of the date of when it was opened. During a review of the facility's admission Record (AR), the AR indicated Resident 94 was admitted on [DATE] with diagnoses that included generalized osteoarthritis (a disease that breaks down one or more joints in the body), dementia (loss of memory, language, problem-solving and other thinking abilities), and dysphagia (difficulty swallowing). During a review of Resident 94's History and Physical Assessment (H&P) dated [DATE], did not indicate if resident had the capacity to understand and make decisions. During a review of Resident 94's Order Summary Report dated [DATE], the Report indicated to apply Diclofenac Sodium External Gel 1% (Topical) to bilateral knees topically two times a day for bilateral knees osteoarthritis apply 4 grams (g, unit of measure) to Resident 94. During a concurrent observation of Medication Cart #4 with LVN 11 on [DATE] at 3:46 PM, an opened tube of Diclofenac Sodium Topical Gel was observed with no label indicating the opened date for Resident 94. LVN 11 stated the medication did not have an open date label. During a review of the facility's AR, the AR indicated Resident 24 was admitted on [DATE] with diagnoses that included hypo-osmolality (condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (condition that happens when the level of sodium in the blood is lower than the typical range), type 2 diabetes mellitus (chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar levels) with (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hyperglycemia (high blood sugar), and intervertebral disc degeneration (condition characterized by the breakdown of one or more of the discs that separate the bones of the spine, causing pain in the back or neck and frequently in the legs and arms). During a review of Resident 24's H&P dated [DATE], indicated resident had the capacity to understand and make decisions. During a review of Resident 24's Order Summary Report dated [DATE], the Report indicated to apply Diclofenac Sodium External Gel 1% (Topical) apply to left and right ankles topically every 6 hours as needed for pain apply 2 g. The Order Summary Report dated [DATE] indicated to apply to right ankle topically at bedtime for right ankle pain apply 2 g. During the same concurrent observation of Medication Cart #4 with LVN 11 on [DATE] at 3:46 PM, an opened tube of Diclofenac Sodium Topical Gel for Resident 24 had no label of the date the tube was opened. LVN 11 stated the medication did not have an open date label. During a review of the facility's AR, the AR indicated Resident 72 was admitted on [DATE] with diagnoses that included encephalopathy, chronic obstructive pulmonary disease with acute exacerbation, and hyperlipidemia. During a review of Resident 72's H&P dated [DATE], did not indicate if resident had the capacity to understand and make decisions. During a review of Resident 72's Order Summary Report dated [DATE], the Report indicated to administer Valproic Acid Oral Solution 250 milligram (mg, unit of measure)/ 5 ml give 5 ml via gastrostomy tube (GT) every 8 hours for mood stabilizer manifested by impulsive behaviors, including attempts to get out of bed without assistance, self-disconnecting from GT, and intermittent resistance to care, informed consent obtained by physician. During the same concurrent observation of Medication Cart #4 and interview with LVN 11 on [DATE] at 3:46 PM, an open bottle of Valproic Acid Oral Solution for Resident 72 had no label of the date the tube was opened During the same interview on [DATE] at 3:51 PM, LVN 11 stated it was important to label medications with opened date after opening to ensure medication is not expired. LVN 11 stated some medications need to be discarded after a certain number of days which was why there needed to be an open date label. LVN 11 stated the medication would not be as effective. A review of the facility's undated policy and procedure (P&P) titled Medication Labeling and Storage, indicated the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The P&P indicated if medication containers have missing incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.		

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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. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in accordance with the facility's policies and procedures, titled storage of Food and Supplies, Procedures for Refrigerated Storage, and to follow Food Code Cooling Cooked Time/Temperature Control for Safety (TCS- any food that that require time and/or temperature controls to ensure food safety) Foods, to prevent the outbreak of foodborne illness (an infection or irritation of the gastrointestinal tract caused by consuming food or beverages contaminated with bacteria, viruses, parasites, or chemical toxins) for 110 of 149 residents receiving food from the kitchen by failing to ensure: Not to store food beyond the used by date 1/25/2026, such as one case of apples, one case of oranges, one case of onions, one case of iceberg lettuce, eleven cups of vanilla yogurt, one five (5)-lb (pound- unit of measurement for weight) tub of sour cream, four plates of chef salads beyond labeled use-by date in the refrigerator. Label and store food that indicated the use-by-date or expiration date for one case of fresh tomatoes and one jar of opened apple sauce, Label food with accurate use-by-date following Food Life Reference for one jar of opened apple sauce, The Kitchen staff follow proper procedures to cool food and record the temperature when storing leftover beans from 2/1/2026 to 2/5/2026. These deficient practices for unsafe hot-holding practices, posing a risk for bacterial growth and foodborne illness and a potential for food contamination (transfer of harmful bacteria or other germs to food, surfaces, or utensils) that placed residents at risk for foodborne illness and lead to other serious medical complications and hospitalization. Findings: During an initial kitchen tour and a concurrent interview on 2/2/2026 from 8:15 AM to 8:45 AM with the Certified Dietary Manager (CDM), the following were observed in the refrigerator: One case of tomatoes with no received-date or use-by-date. One case of apples and one case of oranges labeled use-by date 1/25/2026. One case of iceberg lettuce labeled use-by date 1/25/2026. One case of onions labeled use-by date 1/7/2026. Eleven (11) individually wrapped cups of vanilla yogurt labeled use-by date 2/1/2026. Four (4) plates of chef salads labeled use-by date 2/1/2026 One five (5)-lb tub of sour cream labeled use-by date 1/19/2026 One jar of opened apple sauce with handwriting mark on the lid 1/31/2026 and 2/9/2026 One jar of opened apple sauce with no label use-by date. During the same observation and a concurrent interview on 2/2/2026 at 8:40 AM, the CDM stated the facility received onions and iceberg lettuce on 1/29/2026 but the labels were not placed. The CDM stated that refrigerated foods without label, or labeled with incorrect date, lacking expiration or use-by-date were considered unsafe for resident's consumption. The CDM stated according to facility policy, the kitchen staff are required to properly label and date foods when storing food and supply and in a safe manner. The kitchen staff and cooks are also responsible for disposing food that are past their shelf-life dates. If foods are mislabeled or kept past the shelf-life are provided to the resident, someone could get sick. During an observation and a concurrent interview on 2/2/2026 at 8:45 AM with the CDM, a tray of foil-covered cooked beans with label 2/1/2026 was observed, Cooling log was noted as blank. The CDM stated the cook did not record the temperatures of the beans in the cooling log. The CDM stated it's important to record the temperatures of the beans to make sure the cooling process is being followed as instructed in the log. If the cooks do not cool the food properly, bacteria can grow and it can go bad. During an interview on 2/2/2026 at 8:49 AM with the Kitchen [NAME] (KC) 1, KC 1 stated on 2/1/2026 when he cooled the beans he forgot to document the temperature in the cooling log. KC 1 stated he cooked the beans yesterday around 12 PM and the temperature was 155 F. KC 1 stated he checked the temperature again around 2:30 PM and it was 85 F. KC 1 stated he should have checked the temperature again after that according to the instruction on the log. During a concurrent record review and an interview on 2/6/2026 at 1:45 PM with the CDM, the Cooling log was reviewed. CDM stated he does not have policy for cooling TCS food. CDM stated the instruction on the log provides the steps to follow when (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cooling hot foods. CDM stated the Cooling log was not initialed by the cooks from 2/2/2026 to 2/5/2026 by the cooks and himself as the CDM to indicate that the food temperature was checked and verified that the food cooling was done properly each working day. During a review of the facility's Policy and Procedures (P&P) titled Food Storage: Cold Foods revised in 2/2023, the P&P indicated all food will be appropriately stored in accordance with guidelines of the FDA (Food Drug Administration) Food Code, and all foods will be labeled and dated. During a review of the facility's Food Life Reference Sheet dated 12/2/2022, the sheet indicated the following items and its duration of usability: Sour Cream- seven days after opening Canned fruit (applesauce)- seven days after opening Fresh vegetable/lettuce/spinach/garlic/herb- 7 days whole or cut Fresh whole fruit- seven days		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate communication, verification and documentation of medical records, in accordance with accepted professional standards and practices, for three of six sampled residents (Residents 106, 176, and 168). 1. For Resident 176, LVN 2 failed to ensure accurate communication and verification of a physician order dated 2/5/2026 when LVN 2 documented an order that was not confirmed with the physician. Record review revealed that LVN 2 documented that Resident 176's attending physician (MD 1) had been informed and had provided an order to extend Resident 176's morning medication pass by two hours on 2/5/2026. Interviews revealed that LVN 2 did not notify MD 1 or the covering provider (MD 2 or NP 1) of the anticipated delay in morning medication administration and did not receive an order to extend the morning medication pass by two hours on 2/5/2026. 2. For Resident 168, LVN 2 failed to ensure accurate communication and verification of a physician order dated 2/5/2026 when LVN 2 documented an order that was not confirmed with the physician. Record review indicated that LVN 2 documented an order from the attending physician (MD 2) to extend the resident's morning medication pass by two hours on 2/5/2026. During interviews, MD 2 stated that during an initial telephone call on the morning of 2/5/2026, LVN 2 was instructed to call back to clarify which residents and medications were to be included in the delayed medication administration. LVN 2 did not return the call to MD 2 to provide the requested clarification. Despite the lack of follow-up communication, LVN 2 documented that an order was received from MD 2 to extend the morning medication pass for Resident 168 by two hours on 2/5/2026. These failures resulted in inaccurate medical records and lack of coordination of care, placing Residents 176 and 168 at risk for medication errors, and adverse health outcomes. 3. The facility failed to ensure accurate and truthful documentation of informed consent for a psychotropic medication (Imipramine [anti-depressant]) when RN 3 wrote and backdated the name of DON 2 on Resident 106's Imipramine informed consent form without authorization, and when informed consent was not obtained by the prescribing practitioner prior to initiating the medication. 4. The facility failed to ensure accurate and authorized documentation of informed consent for a psychotropic medication when RN 3 wrote and backdated LVN 3's name on Resident 106's Trazodone [anti-depressant] informed consent form without authorization, and when the prescribing practitioner (PMHNP 1) did not obtain informed consent from the resident's responsible party (Family [FM] 3) prior to initiating the medication. These deficient practices resulted to Resident 106 receiving Trazodone and Imipramine without informed consent from the responsible party, and the medical record contained inaccurate and unauthorized documentation of informed consent from Resident 106's responsible party [FM 3], which had the potential to affect the resident's right to make informed decisions about care and to compromise the integrity of the medical record. Findings: 1. During a review of Resident 176's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with foot ulcer, essential hypertension, and hyperlipidemia. The AC indicated Resident 176 was self-responsible. The AC indicated that Resident 1's primary attending physician is MD 1 and another provider that works under MD 1 is Nurse Practitioner (NP) 1. During a review of Resident 176's History and Physical (H&P) signed and dated by Nurse Practitioner (NP) 1 on 1/30/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 176's physician order dated 2/5/2026 at 10:45 AM, authored by LVN 2, the order indicated a telephone order from MD 1 (Resident 176's attending physician) indicating: May extend AM med [medication] pass up to 2 hours. The physician order lacked specific details, including which specific morning medications were to be extended and the exact timeframe for the extension (start and end times). During a review of Resident 176 electronic Medication Administration Record (MAR) on 2/5/2026 timed at 11:43 AM, Resident (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	176's scheduled 9 AM medications were reviewed. During this review, Resident 176's scheduled 9 AM medications were still not documented as given by a licensed nurse, almost three hours from scheduled time of administration. The AM medications scheduled at 9 AM were Alogliptin 12.5 mg tablet once daily, Norvasc 5 mg oral tablet once daily, Cholecalciferol 1000 units tablet, 2 tablets once daily, Docusate sodium 100 mg tablet once daily, Famotidine 20 mg oral tablet once daily, Gabapentin 300 mg capsule twice daily, and Vitamin B12 tablet 2 tablets once daily. On 2/05/2026 at 4:00 PM, during an attempt to interview Resident 176's attending physician (MD 1), the call was transferred by MD 1's office to the on-call covering physician, MD 3. During the telephone interview, MD 3 stated that he was covering for MD 1, who was on vacation that week. MD 3 further stated that he did not receive any call from the facility or LVN 2 regarding a delay in Resident 176's morning medications on 2/05/2026. MD 3 suggested that LVN 2 may have contacted Nurse Practitioner (NP) 1, who also works under MD 1. During a telephone interview on 2/05/2026 at 4:46 PM, NP 1 stated that he did not receive any phone call from facility staff or a licensed nurse on that date requesting an order to extend medication administration times or informing him of any delay in medications. NP 1 explained that if a medication is unavailable, it is acceptable to adjust administration times; however, there must be documented rationale for why the medication was not given as scheduled. During the same interview, NP 1 emphasized that if Resident 176's morning medications-such as Alogliptin, Norvasc, Gabapentin, and Glipizide-were not administered as scheduled, medical complications could occur because these are critical medications. NP 1 stated he would expect licensed staff to notify him or MD 1 promptly if a resident, including Resident 176, would not receive medications on time so that appropriate adjustments could be made. During a telephone interview on 2/06/2026 at 2:44 PM, LVN 2 stated that on 2/05/2026 she spoke by phone with MD 2 because LVN 1, who was assigned to pass medications for both Residents 176 and 168, was running late. LVN 2 explained that the Director of Nursing (DON 2) asked her to call MD 2 to ask an order for an extension, as they anticipated LVN 1 would be delayed in administering morning medications to her assigned residents. LVN 2 could not recall the exact time of the call to MD 2 but estimated it was around 8:45 AM, while LVN 1 was in Resident 147's room passing medications. LVN 2 stated she informed MD 2 that some of his patients would receive medications late but did not specify resident names or which medications during the call. During the same interview, LVN 2 acknowledged that she mistakenly believed both Residents 176 and 168 were under MD 2's care and assumed MD 2 understood. LVN 2 stated she could not recall why she entered MD 1's name in the physician order for Resident 176 when she only was able to speak to MD 2, (Resident 168's attending physician). During the same interview, LVN 2 stated she had intended to call MD 2 again later that day to provide specific details such as name of medications, name of residents etc., but was unable to do so because she had to leave the facility early that day (2/6/2026). LVN 2 further stated she did not enter the physician order for the two-hour extension at the actual time of the call (around 8:45 AM) but entered at 10:45 AM. During the same interview, LVN 2 further stated she also did not inform Resident 176 and/or 168 and LVN 1 that an extension had been obtained for the administration of the AM medications. LVN 2 confirmed that the documented orders for Residents 176 and 168 were intended for the 9:00 AM medications but did not include a specific timeframe in the orders or the resident's progress notes for the extension that indicated (from 9:00 AM up to 11:00 AM). 2. During a review of Resident 168's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with unspecified complications, hypertension, encounter for orthopedic aftercare following surgical amputation, and acquired absence of left leg below knee. During a review of Resident 168's H&P dated 11/18/2026, the H&P indicated Resident 168 had the capacity to understand and make decisions. During a review of a Resident 168's MDS, dated [DATE], the MDS indicated Resident 168 was cognitively intact. During a review of Resident 168's physician order dated 2/5/2026 timed at 10:43 AM, authored by LVN 2, the order indicated a telephone order from MD 2 (Resident 168's attending physician) indicating: May extend AM med [medication] pass up to 2 hours. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician order lacked specific details, including which specific morning medications were to be extended and the exact timeframe for the extension (start and end times). During a telephone interview on 2/06/2026 at 10:30 AM, MD 2 stated she received a call from a facility nurse (LVN 2) on the morning of 2/05/2026, although she could not recall the exact time. MD 2 stated that LVN 2 informed her that LVN 1 was running late with the morning medication pass for her patients due to CDPH surveyors being present in the facility. MD 2 stated she instructed LVN 2 to call her back once the facility identified which residents under her care were affected and which specific medications were late or anticipated to be late, so that she could determine if any medication adjustments were necessary. During the same interview, MD 2 further stated she received another call later that evening, on 2/05/2026, informing her that Resident 168's medications had already been administered late. MD 2 stated she then provided specific instructions and orders to adjust the administration times for Resident 168's morning and evening medications. During an interview on 2/10/2026 at 1:42 PM, DON 2 stated that when medications are administered late, she expects licensed staff to communicate directly with the physician. DON 2 reported that on 2/05/2026 at approximately 9:45 AM, LVN 2 informed her that LVN 1 was going to be late with the medication pass for Resident 176. DON 2 stated LVN 2 informed her on 2/5/2026 that she had notified the physician (for Residents 176 and 168) that a delay was anticipated and had asked whether the physician wanted to extend the medication pass or hold the medications. During the same interview, DON 2 explained that LVN 2 checked Resident 176's electronic MAR to identify which medications were marked in red, indicating they had not been administered and were past the scheduled time. Medications marked in yellow indicated there was still one hour remaining for administration. DON 2 stated LVN 2 did not follow up with the physician to clarify which medications should be given or held. DON 2 emphasized that any physician order for an extension should have been specific and clearly indicated which medications were to be administered or held. During a review of the facility's policy and procedure (P&P) titled Medication Administration- General Guidelines dated 10/2017 indicated medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The P&P indicated the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. The P&P indicated at the end of each medication pass the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. During a review of the facility's policy and procedures (P&P) titled Charting and Documentation, revised in July 2017, the P&P stated that all services provided to the resident, progress toward care plan goals, and any changes in the resident's medical, physical, functional, or psychological condition must be documented in the resident's medical record. The P&P further stated that documentation in the medical record must be objective (not opinionated or speculative), complete, and accurate. Additionally, documentation of procedures and treatments must include care-specific details, such as: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided care; the assessment data and/or any unusual findings obtained during the procedure/treatment; notification of family, physician, or other staff if indicated; and the signature and title of the individual documenting. During a review of Resident 106's admission Record (AR), the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AR indicated that Resident 106 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Alzheimer's disease (a brain condition that slowly damages your memory, thinking, learning and organizing skills). The AR listed FM 3 as Resident 106's responsible party. During a review of Resident 106's History and Physical (H&P) signed and dated by Nurse Practitioner (NP) 1 on 1/12/2026, the H&P indicated the resident did not have the capacity to understand and make decision. During a review of Resident 106's Minimum Data Set (MDS, a resident assessment tool), dated 12/31/2025, the MDS indicated that Resident 147 has severely impaired cognition (the ability to process thoughts and emotions). During a review of a physician order dated 1/6/2026 timed at 1:06 PM, the physician's order indicated to administer Imipramine 25 mg by mouth at bedtime for depression. The order was entered and confirmed by DON 2 in Resident 106's electronic medical record. During a review of Resident 106's Psychotropic Medication Administration Informed Consent for Imipramine 25 mg, a two-page document dated 1/06/2026 was reviewed. The first page included the following: the prescriber's name was typed as PMHNP 1; the section labeled Prescriber Signature displayed a cursive-style typewritten signature for PMHNP 1, along with a handwritten date of 1/06/2026. The document further indicated, under the Verified section, DON 2's handwritten name with a handwritten date of 1/06/2026. At the bottom of the document, Resident 106's name was also handwritten. The second page of the document included the handwritten psychotropic medication name, Imipramine 25 mg, without FM 3's name and signature. The document further indicated The information above regarding the risk and benefits of psychotropic medication has been verbally explained to me and /or provided in writing During a review of a physician order dated 1/15/2026 timed at 4:38 PM, the physician's order indicated to administer Trazodone 50 mg, one tablet by mouth at bedtime for depression manifested by difficulty sleeping. The order was entered and confirmed by LVN 3 in Resident 106's electronic medical record. During the review of Resident 106's Psychotropic Medication Administration Informed Consent for Trazodone 50 mg, a two-page document dated 1/15/2026 was reviewed. The first page showed the prescriber's name handwritten as PMHNP 1. The section labeled Prescriber Signature displayed PMHNP 1's actual handwritten signature and the date 1/15/2026. Under the Verified section, LVN 3's handwritten name with the same handwritten date was noted. At the bottom of the document, Resident 106's name was also handwritten. The second page included the handwritten psychotropic medication name, Trazodone 50 mg, along with FM 3's handwritten name and signature. The document further indicated The information above regarding the risk and benefits of psychotropic medication has been verbally explained to me and /or provided in writing During a concurrent interview and record review of Resident 106's records on 02/09/2026 at 4:40 PM, Registered Nurse (RN) 1 reviewed Resident 106's electronic medical record and paper chart. RN 1 stated that Resident 106 should have two psychotropic medication informed consents in her medical record-one for Trazodone 50 mg and one for Imipramine. RN 1 stated that during the time of the interview, he could not find documented informed consents for Imipramine and Trazodone in Resident 106's paper chart or electronic medical record. During the same interview, RN 1 stated that all resident consents should be kept in the resident's paper chart. RN 1 further stated that informed consents for psychotropic medications should include the medication name, dosage, indication for the medication, the prescriber's name and signature, and the resident's or responsible party's (RP) name and signature, indicating that the RP had been informed and consented to the administration of psychotropic medication for the resident. RN 1 stated that the informed consent should also include the name and signature of the licensed nurse attesting that he or she verified with the prescriber that the prescriber obtained informed consent from the resident or RP and discussed the risks and benefits prior to the administration of the psychotropic medications. During an observation and concurrent interview on 02/09/2026 at 4:54 PM (14 minutes after the record review with RN 1), DON 1 was observed inside the MDS office with the MDS nurse, RN 3, and the facility's Social Services Director (SSD). During this observation, DON 1 handed over two printed documents for Resident 106 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	titled Psychotropic Medication Administration Informed Consent. The two documents were for Resident 106's psychotropic medications: Trazodone 50 mg and Imipramine 25 mg. During the interview, DON 1 stated that the MDS nurse was keeping the informed consents inside her office for scanning. RN 3 was observed sitting at a desk holding multiple printouts of different residents' Psychotropic Medication Administration Informed Consents. During a telephone interview on 2/9/2026 at 5:15 PM with Resident 106's Family Member 3 (FM 3), FM 3 stated she was the responsible party and decision maker for Resident 106 because Resident 106 did not have the capacity to understand or make decisions due to her Alzheimer's diagnosis. FM 3 stated her primary language is not English and that she often communicates with LVN 3, one of the nurses in the facility who speaks another language. FM 3 recalled that last month, during a visit to the facility, LVN 3 told her that PMHNP 1 visited Resident 106 and wanted to prescribe Trazodone to help calm Resident 106 due to anxiety. FM 3 stated she told LVN 3 she did not want Resident 106 on antidepressants. FM 3 stated LVN 3 explained that the medication would help Resident 106 relax because she (Resident 106) cries at night. FM 3 stated she asked LVN 3 if she could speak to PMHNP 1 because she did not know who this prescriber was or why he was prescribing this type of medication. FM 3 stated LVN 3 told her she would inform PMHNP 1 that FM 3 had questions and wanted to discuss the medication. During the same telephone interview on 2/9/2026 at 5:15 PM, FM 3 stated that as of 2/9/2026, she had not received a phone call from PMHNP 1 to follow up. FM 3 stated she could not recall she had signed any consents or documents for Resident 106's antidepressants because she did not consent to any antidepressant medications. FM 3 stated that if her signature was on a consent form for Trazodone, she most likely signed it along with other documents without fully understanding, as she received many papers from the facility in English. FM 3 stated she had not signed any consents for Imipramine and did not know Resident 106 was taking another antidepressant named Imipramine. During an interview and record review on 02/10/2026 at 10:46 AM of Resident 106's Psychotropic Medication Administration Informed Consent for Trazodone 50 mg with LVN 3, LVN 3 stated that she had not signed or written her name on any consents for Resident 106's psychotropic medications. LVN 3 acknowledged that her name was handwritten under the Verified section of the informed consent for Trazodone but stated she was not the person who wrote it and did not know why someone would write her name on the consent form. LVN 3 stated she had not verified or obtained informed consent for Resident 106's Trazodone. LVN 3 further stated she did not speak to PMHNP 1 or FM 3 to obtain or verify the Trazodone informed consent. During an interview and record review on 02/10/2026 at 11:30 AM of Resident 106's Psychotropic Medication Administration Informed Consent for Imipramine 25 mg with DON 2, DON 2 stated that although her name was written under the Verified By section of the consent, she did not write it and did not know who had written her name or why. DON 2 stated she has been working in the facility since December 2025 and has not obtained or verified any consents for Resident 106. DON 2 stated it is not the facility's practice for staff to write another nurse's name on resident consent forms. DON 2 explained that when a consent is obtained, the nurse who is present and verifies the consent is the only one who should write their name and sign the form. DON 2 stated that falsifying another nurse's name on a consent places residents at risk of receiving medications without their knowledge or consent. During an interview and record review of Resident 106's Psychotropic Medication Administration Informed Consent for Imipramine 25 mg and Trazodone 50 mg with Registered Nurse (RN 3), on 2/10/2026 at 11:59 AM, RN 3 stated she wrote the handwritten informed consent and the handwritten date of 1/6/2026 for Resident 106's Imipramine 25 mg medication on 02/09/2026. RN 3 stated she did not know who had obtained the consent for Resident 106's Imipramine medication. RN 3 explained that she looked at Resident 106's electronic record and saw that DON 2 entered the physician's order for Imipramine 25 mg on 01/06/2026 and assumed that DON 2 had verified that PMHNP 1 obtained consent from the responsible party (FM 3). RN 3 stated she did not ask or verify with DON 2 whether she had verified the consent before writing DON 2's name in Resident 106's Imipramine informed consent. RN 3 further stated she added and typed (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PMHNP 1's name and a cursive-style typed signature on the consent form because PMHNP 1's name appeared in the order as the prescribing physician. During the same interview and concurrent record review of Resident 106's Trazodone 50 mg informed consent on 02/10/2026 at 11:59 AM, RN 3 stated she wrote LVN 3's name by hand under the Verified By section of the form and added the handwritten date of 01/15/2026 on 2/9/2026. RN 3 stated she also wrote the date next to PMHNP 1's signature and FM 3's signature because those sections were left blank on the consent form. RN 3 stated she did not ask LVN 3 whether she had verified that PMHNP 1 obtained informed consent from FM 3 or whether it was appropriate to write LVN 3's name on her behalf. RN 3 explained that she looked at Resident 106's electronic physician order for Trazodone dated 01/15/2026, saw LVN 3's name, and assumed LVN 3 had verified that PMHNP 1 obtained FM 3's informed consent for the medication. RN 3 stated the reason she completed the two consent forms was because DON 1 instructed her to do so on 2/9/2026. During an interview on 02/10/2026 at 1:53 PM with PMHNP 1, PMHNP 1 stated that Resident 106 was a new patient under his care on 1/15/2026. PMHNP 1 stated the first time he conducted an initial assessment for Resident 106 was on 1/15/2026 during a face-to-face visit. PMHNP 1 stated he remembered that Resident 106 spoke a language other than English, and because PMHNP 1 did not speak her primary language, he relied on facility nurses to translate during the assessment. PMHNP 1 stated he was not aware of Resident 106's impaired cognition. PMHNP 1 stated he had not spoken to Resident 106's responsible party (FM 3) before or after his facility visit because he did not know Resident 106 was unable to make health care decisions, as this was not communicated to him by facility nurses. During the same interview, PMHNP 1 stated he did not know FM 3 was Resident 106's responsible party and decision maker, so he did not call FM 3 to explain the risks and benefits of Trazodone, which he prescribed for Resident 106 on 01/15/2026. PMHNP 1 stated he did not know he was required to obtain informed consents for psychotropic medications. PMHNP 1 further stated that he also did not obtain the informed consent for the Imipramine that was dated 1/6/2026.		

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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** Based on observation, interview and record review, the facility failed implement the facility's infection control policy and procedures by failing to: 1a. Ensure the facility's infection control policies binder is readily available to staff as resources to know the list of reportable communicable diseases to the department of health and the state agencies. 1b. Implement the local county's Department of Public Health's recommendation for Influenza (an infection of the nose, throat and lungs) outbreak: 1c.To offer Tamiflu (an antiviral medication used to treat and prevent influenza A and B) to two of two sampled Residents (Resident 128 and 137), who were in close contact with Resident 96 (who tested positive for influenza). 1d.Test for Influenza and monitor for signs and symptoms of Influenza for six of twenty sampled residents (Residents 137, 128, 8, 14, 99, 100, and 85) who were in close contact with Resident 96 and 99. 1e.Identify Resident 34 with influenza when she had cough and cold like symptoms on [DATE], subsequently, was transferred to an acute hospital due to fever and pneumonia (an infection of lung) on [DATE]. 1f Ensure to use the correct test kit for influenza was used and obtained from the laboratory on [DATE], before collecting the sputum specimen from the residents. These deficient practices had the potential to increase the number resident infection due to influenza, leading to physical discomfort, hospitalization, complication, and death among residents.^ 2a. Ensure Licensed Vocational Nurse (LVN) 1 don (put) on an isolation gown when she administered the medications to one of one sampled resident (Resident 147) via gastrointestinal tube (GT- a tube inserted into the stomach to use for medication and fluid administration) Resident 14 was placed on Enhanced Barrier Precautions (EBP, an infection control strategy that is used during high-contact care activities when potential splashing of liquid is anticipated) for the presence of a GT. 2b. Ensure LVN 4 don on an isolation gown when she administered the medications to one of one sampled resident (Resident 153) via GT who was on Enhanced Barrier Precautions for the presence of a G-tube, 3. Licensed Vocational Nurse (LVN) 5 failed to change isolation gown when providing care between 2 of 2 sampled (Residents 117 and 30). Resident 117 who was placed on Enhanced Barrier precautions personal protective equipment (PPE) for enhanced barrier precaution was necessary when performing high-contact care activities that included: dressing and device care or use: feeding tubes to prevent MDRO (Multi-Drug-Resistant^Organisms resistant to multiple medications that treat infection).^ This deficient practice had the potential to result in cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and cause a widespread infection in the facility. Findings: 1. During a review of the facility's policy and procedure (P&P) titled, Influenza Outbreak, dated 4/2025, the P&P indicated the facility follows current guidelines and recommendations for managing influenza outbreak in the facility. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 10/2018, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P also indicated Policies and procedures are utilized as the standards of the infection prevention and control program. During a review of the local county's Public Department's Health's Viral Respiratory Illness Outbreak Notification, dated [DATE], indicated the facility was required to develop and report a line list of that included the residents: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Names of all individuals who are confirmed positive 2. All residents who were hospitalized and expired due to the specific illness outbreak. 3. Have a plan to make testing available within 24 hours, if practicable, to all staff and residents who are close contacts to the resident's affected and regardless of their vaccination status. During a review of the local county Department of Public Health Physician Recommendation and Outbreak Notification Letter, dated [DATE], the letter indicated: 1. To continue to test symptomatic residents. 2. Initiate antiviral treatment (i.e. Tamiflu, Oseltamivir) as soon as possible for all residents/patients with suspected or confirmed influenza, regardless of vaccination history. 3. Treatment should not wait for results of influenza testing. 4. Initiate antiviral chemoprophylaxis (i.e. Tamiflu, oseltamivir) for all non-ill residents/patients and staff who have had contact with influenza or suspect cases. 3. During a concurrent interview and record review on [DATE] at 4:20 PM with the Infection Preventionist Nurse (IPN), the IPN stated the facility's Infection Control (IC) policies were only available online and there was no printed copy available in the facility. The IPN stated she could not find the current list of reportable communicable diseases in the online IC policies, and she was unsure where to obtain the list. The IPN stated it was important for all staff to have access to IC policies and the list of reportable diseases to ensure efficient decision-making, risk mitigation, and compliance. During an interview on [DATE] at 4:29 PM, with Registered Nurse (RN) 1, RN 1 stated he did not know where to find the facility's Infection Control (IC) policies or the current list of reportable communicable diseases. RN 1 indicated that he would report any infection concerns to the Infection Preventionist Nurse (IPN), who was the resource person for providing instructions on how to address such concerns. During an interview on [DATE] at 4:35 PM with RN 2, RN 2 stated she did not know where to obtain the current list of reportable communicable diseases to be reported to the state agency and local department of health. 3a. During a review of Resident 96's admission Record (AR) showed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a serious mental health condition affecting thoughts, feelings, and behavior) and asthma (a respiratory condition causing difficulty breathing from airway swelling, narrowing, and mucus buildup). During a review of Resident 96's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated [DATE], indicated Resident 96 had severely impaired cognition (ability to understand and make decisions) and memory. During a review of Resident 96's Change in Condition Evaluation (CIC), dated [DATE] timed at 1:11 PM, the CIC indicated resident presented with cough and fever at 103.3 degrees Fahrenheit (degrees F) (normal range 96.4 degrees F to 98.6 degrees F. (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 Resident 96's Progress Notes (PN), dated [DATE], the PN indicated Resident 96 was hospitalized and tested positive for influenza at the General Acute Care Hospital (GACH) and returned to the facility where he was placed on Droplet Precautions (keep germs from spreading through close contact by coughing, sneezing and talking). 3b. During a review of Resident 99's AR, the AR indicated the facility originally admitted Resident 99 on [DATE] and readmitted on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD, a term for lung and airway diseases that restrict breathing) and hypertension (high blood pressure). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 had severely impaired cognitive skills for daily decision making. During a review of Resident 99's CIC, dated [DATE] timed at 5:30 AM, the CIC indicated Resident 99 was transferred to GACH for respiratory distress with tachycardia (fast heartbeat) and labored breathing. 3c. During a review of Resident 34's AR, the AR indicated the facility originally admitted Resident 34 on [DATE] and readmitted on [DATE] with diagnoses that include type II diabetes mellitus (a condition that happens when your blood sugar is too high) and hemiplegia (paralysis that affects only one side of your body). During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 had severely impaired cognition and memory. During a review of Resident 34's CIC, dated [DATE] timed at 8 PM, the CIC indicated Resident 34 presented with a cough for one day and was experiencing cold like symptoms. During a review of Resident 34's CIC, dated [DATE] timed at 11:19 AM, the CIC indicated Resident 34's had fever at 101.1 degrees F and her X-ray (a medical imaging that uses radiation to take pictures of the inside of your body) result showed right lower lobes pneumonia (severe infection of the lungs). During a review of Resident 34's PN, dated [DATE] timed at 2:26 PM, the PN indicated Resident 34 was transferred to GACH. 3d. During a review of Resident 137's AR, the AR indicated the facility admitted Resident 137 on [DATE] with diagnoses that include type II diabetes mellitus and hemiplegia. During a review of Resident 137's MDS, dated [DATE], the MDS indicated Resident 137 had intact cognition and memory. During a review of Resident 137's CIC, dated [DATE] timed at 8 PM, the CIC indicated Resident 137 verbalized having cold like symptoms. 3e. During a review of Resident 128's AR, the AR indicated the facility originally admitted Resident 128 on [DATE] and readmitted on [DATE] with diagnoses that include type II diabetes mellitus and hemiplegia. (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 Resident 128's MDS, dated [DATE], the MDS indicated Resident 128 had moderately impaired cognition and memory. 3f. During a review of Resident 8's AR, the AR indicated the facility originally admitted Resident 8 on [DATE] and readmitted on [DATE] with diagnoses that include COPD and type II diabetes mellitus. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had intact cognition and memory. During a review of Resident 8' CIC in PN, dated [DATE] timed at 6:10 AM, the CIC indicated Resident 8's was transferred to the GACH on [DATE] due to oxygen saturation (oxygen level in the blood is carrying) decreased to 84% and increased to 94% when oxygen was increased to five (5) liters per minute, heart rate 127 per minute, and had vomiting and abdominal (stomach) pain. 3g. During a review of Resident 14's AR, the AR indicated the facility admitted Resident 14 on [DATE] with diagnoses that include acute respiratory failure (the loss of the ability to ventilate adequately or to provide sufficient oxygen to the blood and systemic organs) and pneumonia. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had severely impaired cognition and memory. 3h. During a review of Resident 100's AR, the AR indicated the facility admitted Resident 100 on [DATE] with diagnoses that include type II diabetes mellitus and hypertension. During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100 had intact cognition and memory. 3i. During a review of Resident 85's AR, the AR indicated the facility originally admitted Resident 85 on [DATE] and readmitted on [DATE] with diagnoses that include chronic systolic heart failure (CHF, a chronic condition where the heart cannot pump enough blood to meet the body's needs, causing fluid to build up in the lungs, legs, and body) and type II diabetes mellitus. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 had severely impaired cognition and memory. During an interview on [DATE] at 11:41 AM with Family Member (FM) 2, FM 2 stated Resident 99 was transferred to a hospital on [DATE] due to respiratory distress and the resident was tested positive of influenza upon arrival and was intubated (a procedure of inserting a tube into the windpipe, while a ventilator is the machine that helps with breathing) in the hospital. During an interview on [DATE] at 12:59 PM with Family Member (FM) 1, FM 1 stated Resident 34 was transferred to the acute hospital due to fever and pneumonia on [DATE] and the resident tested positive of Influenza A at the hospital. During a concurrent interview and record review on [DATE] at 3:08 PM with the IPN, Influenza and Respiratory Outbreak Line List for Healthcare Facilities-Residents, dated [DATE], was reviewed. The IPN stated Resident 96 was transferred to GACH due to cough and fever on [DATE] where the resident tested positive for influenza A. Resident 96 returned to the facility on [DATE]. IPN stated she did not test the roommates Resident 8, 128 and 137 for influenza because these residents were (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asymptomatic. During an interview on [DATE] at 3:09 PM with the IPN, the IPN stated Resident 99 was transferred to an acute hospital due to respiratory distress due to tachycardia (rapid heart rate) and labored breathing. The IPN stated FM 2 informed the facility that Resident 99 was tested at the GACH for influenza that resulted positive. The IPN stated Resident 99 resided in Room B and she did not test the roommates Resident 85, 100 and 14 because these residents were asymptomatic. During a concurrent interview and record review on [DATE] at 3:10 PM, the Line List of Close Contact (Residents), dated [DATE], was reviewed. The IPN stated the current Line List of Close Contact only included symptomatic residents and she only tested the symptomatic residents for influenza. During a concurrent interview and record review on [DATE] at 3:12 PM, Resident 137's CIC, dated [DATE], was reviewed. The IPN stated she was unaware that Resident 137, roommate of Resident 96, had cold like symptoms on [DATE] until informed by the surveyor. The IPN stated the nursing staff did not notify her, so Resident 137's condition was not assessed or included in the Line List of Close Contact for monitoring and influenza testing. During a concurrent interview and record review on [DATE] at 3:14 PM with the IPN, the facility's Influenza Outbreak, dated 4/2025, was reviewed. The IPN stated she was not aware of the facility's policy or guidance for testing residents with symptoms for Influenza and so she only tested the symptomatic residents. During an interview and record review on [DATE] at 3:15 PM with the IPN, the local county Public Health's Viral Respiratory Illness Outbreak Notification and the local Department of Public Health Physician Recommendation and Outbreak notification Letter, dated [DATE], were reviewed. The IPN stated the Public Health recommendation indicated to test residents who were in close contacts of the positive cases and the roommates of Resident 96 and 99 (Resident 137, 128, 8, 14, 100, and 85) should be included in the Line List of Close Contacts for close monitoring, testing and treatment. 4. During an interview on [DATE] at 3:18 PM with the IPN, the IPN stated the physician ordered Tamiflu to the residents who were in close contact with Residents 96 and 99, but the residents did not respond yet. During a concurrent observation and interview on [DATE] at 4:38 PM with Resident 128, Resident 128 denied being offered Tamiflu by the facility. During an interview on [DATE] at 4:43 PM with Resident 137, Resident 137 stated he had cold like symptoms last week and the nurse did not offer Tamiflu or any medication to treat influenza. During an interview on [DATE] at 4:52 PM with the IPN, the IPN stated she failed to document that she offered [NAME] flu to Resident 128 and 137. During an interview on [DATE] at 4:55 PM with the IPN, the IPN stated that she tested symptomatic residents for influenza on [DATE] and sent specimens to the lab. On [DATE], the lab informed the facility that the wrong test kits (Type 1) were used, making the tests invalid. The correct kits (Type 2) were received on [DATE], and the IPN had to retest close contacts. The IPN explained she previously used Type 1 kits for COVID testing in August and assumed they could also be used for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	influenza without verifying with the lab, which led to the error. During an interview on [DATE] at 12:59 PM with the IPN M, the IPN stated that Resident 34 developed cough and cold symptoms on [DATE] and was transferred to an acute hospital on [DATE] due to fever and pneumonia. After the influenza outbreak was announced on [DATE], the IPN did not follow up with the hospital or family regarding Resident 34. She was unaware that Resident 34 tested positive for influenza at the hospital until informed by facility staff through the family. As a result, Resident 34 was not included on the line list for positive cases or close contacts. The IPN acknowledged that she should have confirmed the diagnosis to identify close contacts, track infection spread and prevent further transmission. During an interview on [DATE] at 2:25 PM with the Director of Nursing (DON) 2, stated that the IPN should follow the Department of Public Health's recommendations for managing the current influenza outbreak to implement appropriate interventions and prevent the spread of influenza to other residents. 2.During a review of Resident 147's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included gastrostomy (pertains to the presence of a gastrostomy tube or G-tube, a small plastic feeding tube that is used to deliver medication or liquid solution directly to the resident's stomach), dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, reasoning, and communication), and dysphagia (difficulty in swallowing). ^^ During a review of Resident 147's care plan for enhanced barrier precautions (EBP), initiated [DATE], the care plan indicated that the resident was placed on EBP related to the resident's G-tube. The care plan included a goal that the resident will not have infections of MDROs (multi-drug-resistant organisms, bacteria that is resistant to multiple antibiotic medications). The care plan also included interventions for staff to adhere to the facility's personal protective equipment compliance. During a review of Resident 147's History and Physical (H&P), dated [DATE], the H&P indicated that Resident 147 had fluctuating capacity to understand and make decisions. ^ During a review of Resident 147's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated that Resident 147 has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (helper does all the effort) in activities such as oral hygiene, bathing, and moving in bed from left to right. ~~~~ During a review of Resident 147's physician's order dated [DATE], the order indicated for staff to implement enhanced barrier precautions on Resident 147 related to the resident's G-tube. ^ During an observation on [DATE] at 8:36 AM inside Resident 147's room, LVN 1 was observed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering Resident 147's room without wearing an isolation gown. LVN 1 was observed touching Resident 147's G-tube. During a medication administration observation on [DATE] from 8:38 AM to 8:49 AM, LVN 1 did not wear an isolation gown when she administered Resident 147's medications via the resident's G-tube. During the medication administration observation, LVN 1's clothes were observed touching the resident's bed linens multiple times. During an interview on [DATE] at 8:54 AM, LVN 1 stated that she forgot to wear an isolation gown when she provided care to Resident 147. LVN 1 stated she is aware that Resident 147 is on EBP because of the resident's G-tube. LVN 1 added that the purpose of following EBP is to prevent the spread of infections from one resident to another. During a concurrent interview and record review on [DATE] at 8:58 AM with LVN 1, the signage by the door to Resident 147's room titled, Enhanced Barrier Precautions, was reviewed. LVN 1 stated the signage indicates that staff must wear gloves and gowns for high-contact resident care activities such as providing care related to Resident 1's g-tube. During a review of Resident 153's AR, the AR indicated that the resident was admitted originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (occurs when the lungs cannot properly transfer oxygen into the blood), tracheostomy (a surgically created hole in the windpipe), gastrostomy, and dependence on a respirator (a machine used to help a person breathe). During a review of Resident 153's H&P, dated [DATE], the H&P indicated that the resident has fluctuating capacity to understand and make decisions. During a review of Resident 153's MDS, dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS also indicated that the resident is dependent in activities such as oral hygiene, bathing, and moving in bed from left to right. During a review of Resident 153's physicians orders, dated [DATE], the order indicated to implement EBP related to the resident's use of indwelling devices and wounds, G-tube and tracheostomy tube. During an observation and interview on [DATE] at 9:10 AM inside Resident 153's room, LVN 4 was observed going into Resident 153's room without wearing an isolation gown. LVN 4 was observed touching Resident 153's left arm and stated that she was going to check Resident 153's blood pressure. During a medication administration observation and interview on [DATE] at 9:18 AM to 10:00 AM, LVN 4 did not wear an isolation gown when she administered Resident 153's medications via the resident's G-tube. During the medication administration observation, LVN 4's clothes were observed touching the resident's left arm and bed linens multiple times. During an interview on [DATE] at 10:00 AM, LVN 4 stated she forgot to wear an isolation gown when she administered Resident 153's medications and when she checked the resident's blood pressure. LVN 4 stated that EBP must be implemented to protect all residents from infections. LVN 4 stated wearing an isolation gown protects the nurses' gowns from bacteria that could potentially spread from resident to resident. (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 interview and record review on [DATE] at 10:11 AM with LVN 4, the signage by the door to Resident 153's room titled, Enhanced Barrier Precautions, was reviewed. LVN 4 stated that the sign instructed staff to wear gloves and an isolation gown when providing care to the resident's g-tube. During an interview on [DATE] at 1:21 PM with the Director of Nurses (DON) 2, DON 2 stated that when nurses take care of residents that have a G-tube, nurses should wear the complete personal protective equipment (PPE) such as an isolation gown and gloves because of the potential for liquid splashing from the G-tube. DON 2 stated that wearing the correct PPE helps in the prevention of the spread of bacteria from resident to resident. During a review of the facility's policy and procedures (P&P) titled, Enhanced Standard/Barrier Precautions, revised [DATE], the P&P indicated that the facility implements EBP for the prevention of transmission of multidrug-resistant organisms. The P&P also indicated that PPE is necessary when performing high-contact care activities, which includes device care or use of feeding tubes or G-tubes. The P&P also indicated that EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 3. A review of the facility's policy and procedure (P&P) titled Enhanced Standard/Barrier Precautions revision dated [DATE] indicated personal protective equipment (PPE) for enhanced barrier precautions was necessary when performing high-contact care activities that included: dressing and device care or use: feeding tubes. A review of the facility's P&P titled Infection Prevention and Control Program, dated 10/2018 indicated the facility established an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of Resident 117's admission Record (AR) indicated that the resident was admitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing) presence of a gastrostomy tube (G-tube-which is a small plastic feeding tube used to deliver medication or liquid nutrition directly to the resident's stomach) dementia (a condition characterized by a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, reasoning, and communication. During a review of Resident 117's History and Physical (H&P), dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. During a review of Order Summary Report, dated [DATE], indicated a physician order placed Resident 117 on Enhanced Standard Precautions related to the use of G-tube device. During a review of Resident 117's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated that Resident 117 had moderately impaired cognition (the ability to process thoughts and emotions). ~~~~~ During a review of Resident 117's care plan for enhanced barrier precautions (EBP), initiated on [DATE], indicated that the resident was placed on EBP related to the resident's G-tube. The care plan included a goal to prevent infection caused by MDRO (Multi-Drug-Resistant Organisms resistant to multiple medications that treat infection). The care plan included [TRUNCATED]		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 170) who was transferred to the GACH on 12/12/2026 was provided written information regarding the facility and state bed-hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave) as indicated in the facility's policy and procedure. As a result of this deficient practice Resident 170's rights to return to the facility after hospitalization could be violated. Findings: During a review of the facility's P&P titled, Bed-Holds and Returns, dated 10/2022, the P&P indicated All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). During a review of Resident 170's admission Record (AR), the AR indicated the facility admitted Resident 170 on 3/19/2025 with diagnoses that include type II diabetes mellitus (a condition that happens when your blood sugar is too high) and hyperlipidemia (high levels of fats in the blood). During a review of Resident 170's Minimum Data Set (MDS, a resident assessment and care planning screening tool), dated 10/6/2025 indicated Resident 170 had no cognitive impairment. During a review of Resident 170's Minimum Data Set (MDS, a resident assessment and care planning screening tool), dated 12/12/2025, indicated Resident 170 was discharged to a short-term general acute care hospital on [DATE]. During a concurrent interview and record review on 2/6/2026 at 2:07 PM with the Assistant MDS Nurse (AMDSN), Resident 170's medical record was reviewed. The AMDSN stated Resident 170 was transferred to a General Acute Care Hospital (GACH) due to fall on 12/12/2025. The AMDSN stated there was no record in Resident 170's medical record to transfer the resident to the GACH and no bed hold order for the resident transcribed in the resident's medical records. During a concurrent interview and record review on 2/6/2026 at 2:15 PM with the AMDSN, Resident 170's Bed Hold Policy Notice & Authorization was reviewed. The AMDSN stated there were no specific dates of the bed hold, no resident/representative and facility representative signatures, and no signing date, indicated on the Bed Hold Policy Notice & Authorization. The AMDSN stated there was no documented evidence indicating the facility staff provided the bed hold notice to Resident 170 when he was transferred to the GACH. During an interview on 2/6/2026 at 2:17 PM with the AMDSN, the AMDSN stated the nurse should have obtained a physician order to transfer Resident 170 to the GACH and a bed hold order. The AMDSN stated it was important to obtain a bed hold order from the resident's physician and provide a bed hold notice to the resident to ensure the resident was informed of his rights to return to the facility during the bed hold. The AMDSN stated she did not know why the nurse who transferred Resident 170 to GACH did not obtain a physician order and informed Resident 170 of his rights about the bed hold notice to Resident 170. During an interview on 2/10/2026 at 2:20 PM with Director of Nursing (DON) 2, DON 2 stated the nurses should obtain a physician order to transfer Resident 170 to the GACH and transcribe the transfer order in Resident 170's medical record. DON 2 stated the nurse should have obtained a physician order for bed hold and keep the notice in the resident's medical record and provide the bed hold notice to the resident to ensure their rights to return to the facility was respected and honored. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, dated 2001, the P&P indicated Transfer and discharge must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of resident's admission to the facility for one of three (3) sampled residents (Resident 176) reviewed for baseline care plans for Type 2 Diabetes Mellitus (DM-an adult-onset disease in which the blood glucose or sugar levels are too high). This deficient practice had the potential for Resident 176 not to receive the appropriate resident specific interventions, treatments and medications necessary for Resident 176's care. Findings: During a review of the facility's policy and procedure (P&P) titled Care Plan-Baseline, dated of 8/25/2021, the P&P indicated The baseline care plan is developed within 48 hours of a resident's admission. The baseline care plan includes the minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders, Physician orders . During a review of Resident 176's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with foot ulcer, essential hypertension, and hyperlipidemia. During a review of Resident 176's History and Physical (H&P) signed and dated by Nurse Practitioner (NP) 1 on 1/30/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 176's Care Plan titled Baseline Care Plan: Resident [176] is newly admitted to the facility initiated and created with a date of 2/02/2026 (3 days after facility admission). The care plan did not specify which of Resident 176's needs at the facility would be met such as specific treatments, diagnosis or medications. During a review of Resident 176's care plan titled Resident 176 has hyperglycemia (a condition in which a person's blood glucose level is higher than normal)/hypoglycemia (a condition occurring when blood glucose drops below healthy levels) related to Diabetes with an initiation and created date of 2/02/2026 (3 days after facility admission). During an interview and concurrent record review on 2/05/2026 at 10:30 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that she was the admitting nurse for Resident 176 on 01/30/2026. LVN 3 stated Resident 176 was admitted to facility with a diagnosis that included Type 2 Diabetes Mellitus with foot ulcer and there was no baseline care plan initiated on Resident 176's admission from 1/30/2026 through 2/02/2026 . LVN 3 stated the baseline care plan should had been initiated during admission, but she forgot and assumed the incoming shift licensed nurses would complete any missing baseline care plans and assessments as it was the end of her shift on 1/30/2026. During an interview on 02/05/2026 at 4:58 PM with the Director of Nursing (DON 2), DON 2 stated that all residents' baseline care plans should be initiated within 48 hours of admission. DON 2 stated that Resident 176's baseline care plan should have been initiated by the licensed nurses when the resident was admitted to the facility on [DATE]. DON 2 further stated that failure to create a baseline care plan could result in the resident not receiving appropriate, resident-specific interventions and monitoring.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to develop and implement a resident specific comprehensive, person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for three of four sampled residents (Resident 1, Resident 14, and Resident 44) by failing to: a. Develop and implement a care plan for Resident 1 who was receiving Ativan (a prescription medication used for short-term treatment of severe anxiety, panic disorders, and insomnia), trazodone hydrochloride (HCL, a prescription medication primarily used to treat depression), and divalproex sodium (Depakote, a prescription medication used to control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and treat manic episodes [a period of intense, elevated mood or extreme irritability accompanied by a surge in energy]) and did not address the resident's dementia (a progressive state of decline in mental abilities) diagnosis. b. Develop and implement a care plan for Resident 14 who was assessed to be at risk for developing pressure injury (PI- localized damage to the skin and/or underlying tissue due to prolonged unrelieved pressure, sheer and friction usually over a bony prominence). c. Implement Resident 44's care plan to provide language interpreter services such as language line as Resident 44 was Cantonese speaking. These deficient practices had the potential for a lack of individualized care and result in more than minimal harm, including unmanaged behaviors, adverse medication effects, or decline in the resident's condition. For Resident 14 not to receive or received delayed interventions to prevent the development of PI for Resident 14 and for Resident 44 not being able to effectively communicate his needs and reported feeling sad because he could not understand or make himself understood by staff placing him at risk for psychosocial harm and unmet needs. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included dementia, depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and anxiety disorder (a mental health condition marked by excessive, persistent, and uncontrollable worry or fear about everyday situations, going beyond normal nervousness and interfering with daily life, work, and relationships). During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 12/5/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident's active diagnoses included dementia, depression, and anxiety disorder. The MDS indicated the resident was receiving antipsychotic, antianxiety, and antidepressant medications. During a review of Resident 1's History and Physical (H&P) dated 1/4/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report dated 1/21/2026, the Order Summary Report indicated divalproex sodium, oral tablet, delayed release (designed to pass through the stomach intact and release medicine later in the small intestine) 500 milligrams (mg, unit of measurement), give 500 mg by mouth three times a day manifested by labile mood (experiencing rapid, intense, and often uncontrollable shifts in emotions). During a review of Resident 1's Comprehensive (complete) Care Plan, the Care Plan did not include (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's diagnoses of dementia or the resident's use of Ativan, trazadone, and divalproex as a focused care plan. During a review of Resident 1's Order Summary Report dated 2/7/2026, the Order Summary Report indicated trazodone HCL oral tablet 50 mg, give 0.5 tablet by mouth at bedtime for depression manifested by inability to sleep plus six hours. During a review of Resident 1's Order Summary Report dated 2/9/2026, the Order Summary Report indicated Ativan oral tablet, one mg, give one tablet by mouth every 12 hours for anxiety manifested by aggressive behaviors manifested by striking at staff, for 14 days. During a concurrent interview and record review of Resident 1's Comprehensive Care Plan on 2/9/2026 at 3:01 PM, the Licensed Vocational Nurse (LVN) 8 stated the resident did not have a dementia care plan but should have had one so the facility staff could implement interventions for Resident 1's dementia. LVN 8 stated the care plan lets the facility staff know what they should have been doing for the resident including the goals and interventions, otherwise the facility staff would not be applying that to the resident's daily care. During a concurrent interview and record review of Resident 1's Comprehensive Care plan on 2/10/2026 at 10:02 AM, LVN 9 stated the resident did not have a care plan for Ativan, trazadone, and divalproex but should have had one for each of those medications. LVN 9 stated there should have been a care plan for each of those medications so that facility staff would know what medications the resident was receiving and why he was on them. LVN 9 stated monitoring the resident's behavior was important and knowing which medications he was on would help with that. During a concurrent interview and record review of Resident 1's Comprehensive Care Plan on 2/10/2026 at 12:48 PM, the Director of Nursing (DON) 1 stated the resident did not have a dementia care plan but should have had one. DON 1 stated care plans needed to be individualized to the patient based on their diagnosis so facility staff would know how to care for the resident. DON 1 stated without a care plan, the resident could hurt themselves and the facility staff would not know the proper techniques to de-escalate the situation if they did not know the resident had dementia. During a concurrent interview and record review of Resident 1's Comprehensive Care Plan on 2/10/2026 at 1:07 PM, DON 1 stated there should have been a care plan each of the resident's medications: Ativan, trazadone, and divalproex. DON 1 stated because each of those medications were different and each of the care plans would have had different goals and interventions. DON 1 stated if those medications were lumped into one category, then the facility staff would be monitoring the same thing, but the facility staff should be monitoring different things for the different medications. b. During a review of Resident 14's admission Record (AR), the AR indicated that the facility admitted Resident 14 on 11/3/2025 with diagnoses that included acute respiratory failure (low oxygen level in the blood), hypertension (high blood pressure), and dysphagia (difficulty swallowing). ~ During a review of Resident 14's Minimum Data Set (MDS &ndash; a resident assessment tool) dated 11/18/2025, the MDS indicated that Resident 14 had severe cognitive (thought process) impairment (rarely/ never makes decision). The MDS indicated that Resident 14 was (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dependent (helper does all the effort) on rolling left and right, sit to lying, and chair/bed-to-chair transfer." During a review of Resident 14's Braden Scale for Predicting Pressure Ulcer Risk (a skin assessment tool that determine the resident's risk for developing pressure ulcer), dated 11/11/2025, indicated Resident 14 was at risk for developing pressure ulcer. During a review of Resident 14's Documentation Survey Report (a form completed by the certified nursing assistants [CNAs]), dated from 1/1/2026 to 2/4/2026 indicated to Turn and Reposition per resident comfort and as needed. During a record review of the Documentation Survey Report with the Director of Staff Development (DSD) on 2/6/2026 at 11:15 AM, indicated Resident 14 was turned and repositioned over the 24 period from 1/1/2026 to 2/4/2026. The record indicated Resident 14 was repositioned when needed. During a review of Resident 14's Care Plan, there was no comprehensive care plan developed based on the turning and repositioning resident based on resident's comfort and as needed. During a concurrent observation of Resident 14's skin and an interview on 2/4/2026 at 2:40 PM with licensed vocational nurse (LVN) 6, LVN 6 stated Resident 14's sacrococcyx (bottom of the spine and tailbone) skin was red, non-blanchable (skin redness or spots that do not turn white when pressed). LVN 6 stated that Resident 14 does not have any special mattress and should had been reposition every two hours. LVN 6 stated she was not sure last time Resident 14 was repositioned. ^ During a concurrent interview and record review on 2/4/2026 at 2:55 PM with LVN 6, Resident 14's Braden Scale, Documentation Survey Report and Care Plan were reviewed. LVN 6 stated the survey report indicates the resident will be repositioned based on the resident's comfort and as needed. LVN 6 stated Resident 14 was at risk for developing PI and the care plan should have included interventions to prevent development of PI such as offloading pressure areas by turning and repositioning. During an interview on 2/9/2025 at 9:30 AM, the Director of Nursing (DON) stated that licensed nursing staff are responsible for creating a comprehensive care plan when a resident's risk for skin breakdown was identified in the Braden Score on 11/11/2025. The DON emphasized that without a comprehensive care plan, staff cannot provide person-centered care or evaluate the effectiveness of interventions. During a review of the facility's policy and procedure (P&P) titled Skin Integrity Management dated 5/26/2021, the P&P indicated the following: -Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. -Implement pressure ulcer prevention for identified risk factors -Determine the need for support surface for bed and chair. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Determine the need for offloading devices. -Turning and repositioning based on resident care needs. During a review of the facility's P&P titled Care Plan Comprehensive revised 8/25/2021, the P&P indicated that the facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment. c. During a review of Resident 44's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included arthritis (inflammation, pain, stiffness, and swelling in one or more joints), gout (a common, painful form of inflammatory arthritis caused by too much uric acid [a waste product created when the body broke down chemicals called purines] in the blood), and generalized muscle weakness. During a review of Resident 44's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 11/26/2025, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident's speech was clear, was able to make himself understood, and was able to understand others. During a review of Resident 44's Social Services Assessment and Documentation dated 11/20/2025 at 1:44 PM, the Assessment indicated the resident was independent, self-responsible, and the resident's primary language was Cantonese. During a review of Resident 44's Impaired Communication Care Plan dated 11/20/2025, the Care Plan indicated the resident had a language barrier as Resident 1 was Cantonese speaking. The Care Plan provided an interpreter line number with a facility identification and a goal to be able to make basic needs known on a daily basis. The Care Plan indicated interventions to provide language interpreter services such as language line, as indicated and to allow sufficient time for the resident to process and respond. During a concurrent observation and interview in Resident 44's room on 2/2/2026 at 11:01 AM, Resident 44 did not have a bilingual communication board (a simple, visual tool often a sheet with pictures, symbols, or words to bridge language gaps and ensure resident needs were met) in the resident's room. During the surveyor's introduction, the resident did not respond and would only nod his head and when asked if he preferred another language, the resident stated Chinese. During the interview with the Chinese interpreter, Resident 44 stated he did not communicate with the facility staff because the facility staff did not understand him and rarely had a Chinese interpreter. Resident 44 stated that when he received therapy or was offered a shower, the facility staff would give a gesture and he could understand that, but nothing else. Resident 44 stated he could not explain or talk to facility staff and felt very sad because nobody understands me. During an interview on 2/2/2026 at 12:50 PM, the Certified Nursing Assistant (CNA) 3 stated the resident did not have a communication board but should have had one. CNA 3 stated without a communication board the resident would not be able to let the facility staff know what he needed and the facility staff would also not know what the resident needed. During an interview on 2/9/2026 at 3:28 PM, the Licensed Vocational Nurse (LVN) 5 stated she did (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know the resident could not understand the facility staff because he was usually very quiet, did not talk, and did not complain and therefore LVN 5 thought the resident was okay. LVN 5 stated if the resident was unable to understand the facility staff, the resident could be sad or depressed because he could not communicate or express his needs for the facility staff to know. During an interview on 2/10/2026 at 1:20 PM, the Director of Nursing (DON) 1 stated Resident 44 should have had a communication board or translator line in the resident's room for the facility staff to understand the resident otherwise there could be confusion for both the resident and the nurse. DON 2 stated if the facility staff were unable to understand the resident, Resident 44 could feel anxious because he felt like he was not being taken care of or was unable to express his preferences. During a review of the facility's policy and procedure (P&P) dated 8/25/2021, the P&P indicated The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated Each resident's comprehensive care plan is designed to: build on the resident's individualized needs, strengths, preferences; reflect treatment goals, timetables, and objectives in measurable outcomes; and identify the professional services that are responsible for each element of care. The P&P indicated, The comprehensive care plan includes the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and systematic clinical decision making. The P&P indicated Assessments of residents are on going and care plans are reviewed and revised as information about the resident and the resident's condition change. The Interdisciplinary Team is responsible for evaluation and updating of care plans: when there has been a significant changes in the resident's condition, when the desired outcome is not met, and when the resident has been readmitted to the facility form a hospital stay; and at least quarterly. During a concurrent interview and record review on 2/10/2026 at 1:26 PM of the facility's policy and procedure (P&P) titled, Accommodation of Needs dated November 2025, the P&P indicated The resident's individual needs and preferences are accommodated to the extent possible by the facility and staff. Staff are trained and expected to assist the resident's in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. For example: interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services to assist three sampled residents (Resident 28, 24 and 73) who needed assistance with grooming such as haircut. These deficient practices had resulted in residents not maintaining good personal hygiene and clean appearance which could negatively affected their self-image and dignity. Findings: 1. During a review of Resident 28's admission Record (AR), the AR indicated the facility admitted Resident 28 on 12/4/2024 with diagnoses that include chronic obstructive pulmonary disease (a term for lung and airway diseases that restrict breathing) and hypertension (high blood pressure). During a review of Resident 28's Minimum Data Set (MDS, a resident assessment and care planning screening tool), dated 12/5/2025, indicated Resident 28's had no cognitive impairment (ability to understand and make decisions) and required supervision with personal hygiene. 2. During a review of Resident 24's AR, the AR indicated the facility originally admitted Resident 24 to the facility on 6/6/2019 and readmitted on [DATE] with diagnoses that included type II diabetes mellitus (a condition that happens when your blood sugar is too high) and hypertension. During a review of Resident 24's MDS, dated [DATE], indicated Resident 24's had no cognitive impairment and was independent with activities of daily living including personal hygiene. 3. During a review of Resident 73's AR, the AR indicated Resident 73 was admitted to the facility on [DATE] with diagnoses that include hemiplegia (paralysis that affects only one side of your body) affecting right dominant side and type II diabetes mellitus. During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's was moderately impaired with cognition and memory. The MDS indicated Resident 73 required substantial/moderate assistance with personal hygiene. During a concurrent observation and interview on 2/5/2026 at 1:05 PM with Resident 28, Resident 28 was sitting on a wheelchair. In an interview Resident 28 stated he had not received the haircut schedule from the facility and the facility was not offered or provided assistance with getting a haircut since November last year (2025). Resident 28 stated in the past, the activity and social services staff would arrange the hair cut events for the male residents, but they had not arranged any haircut events for the male residents since last November. Resident 28 stated last month as he was passing by a room down the hallway, he saw a lady was cutting hair of the female residents, so he asked the lady if she could cut his hair too and the lady agreed. Resident 28 stated he would like to get a haircut every month so he could maintain good personal hygiene and a clean look. During a concurrent observation and interview on 2/5/2026 at 1:19 PM Resident 24 was seated in a wheelchair and stated he requires the wheelchair for mobility. Resident 24 stated that the facility has not offered haircut services for male residents for two to five months. As a result, Resident 24 had to ask a friend to take him outside the facility and pay for a haircut himself. During a concurrent observation and interview on 2/5/2026 at 1:34 PM, Resident 73 was sitting on a wheelchair with a splint (a medical device to immobilize an injured limb) on his right hand. Resident 73 had short hair on the sides but long, curly hair on the top and back. Resident 73 explained he was hospitalized for a month and requested a haircut upon admission to the facility, but it had not been provided. Resident 73 showed a pair of blunt children's scissors he used to trim the sides of his hair himself, leaving the top and back long because he could not cut the hair on top and back of his head. Resident 73 stated he dislikes his current hairstyle and prefers short and clean hair to look presentable and does not have money to pay for a haircut. During an interview and record review on 2/5/2026 at 1:44 PM, the Social Services Director (SSD) stated that the person who previously provided haircut services for male residents resigned in December of last year. The facility has been trying but has not yet found a qualified replacement. The SSD admitted she did not inform or assist the three male residents (Resident 28, 24 and 73) or their responsible parties about options for transportation and financial assistance to get haircuts outside the facility. The DSD acknowledged (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the importance of assisting residents maintain good personal hygiene, a clean-cut appearance, and dignity while the service is unavailable. During an interview on 2/9/2026 at 2:53 PM with Director of Nursing (DON) 2, DON 2 stated the importance of providing haircut to the residents was to preserve their dignity, particularly for Resident 73 who is hemiplegic (unable to move one side of the body) and to ensure safety and prevent injury when trimming his own hair. During an interview on 2/9/2026 at 2:53 PM with Director of Nursing (DON) 2, emphasized the importance of providing haircuts to preserve residents' dignity, particularly for Resident 73, who is hemiplegic, to ensure safety and prevent self-trimming. During a review of the undated facility's policy and procedure (P&P) titled, Dignity, the P&P indicated Each resident is cared for in a manner that promotes and enhances individually, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's P&P titled, Activities and Social Services, dated 4/25/2025, the P&P indicated Residents shall have the right to choose the types of activities and social events in which they wish to participate as long as such activities do not interfere with the rights of other residents in the facility. Residents are encouraged to choose the types of recreational, cultural, and religious activities and social events in which they prefer to participate. as much as possible, the facility will provide activities, social events, and schedules that are compatible with the resident's interests, physical and mental assessment, and overall plan of care. Residents who wish to meet with or participate in the activities of social, religious, and other community groups, at or away from the facility, will be encouraged to do so. As much as possible, the facility will help the individual arrange to reach these outside activities, but the facility may not necessarily provide the transportation. During a review of the facility's P&P titled, Social Services, dated 9/2021, the P&P indicated The facility staff is able to identify and address factors that have a potentially negatively effects on psychological functioning of a resident, for example: a. situations that impede the resident's dignity and sense of control. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting, dated 3/2018, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide care and services to ensure the licensed staff reviewed Resident 176's General Acute Hospital (GACH) records for all appropriate discharge orders in accordance with professional standards of practice and the facility's policy and procedure (P&P) titled Reconciliation of Medication on Admission. This failure occurred for one of one sampled resident (Resident 176), who had a diagnosis of Type 2 diabetes mellitus (a disease in which blood sugar levels are too high). This deficient practice resulted in Licensed Vocational Nurse (LVN) 3 failing to transcribe three diabetic medications- Glipizide (used to lower blood sugar levels), Alogliptin (used to lower blood sugar levels), and Insulin Lispro (a fast-acting form of insulin, a hormone produced by the pancreas to lower blood sugar)-from the General Acute Care Hospital (GACH) 1 Patient Discharge Instructions upon Resident 176's admission to the facility on 1/30/2026. As a result, multiple doses of oral hypoglycemics were omitted from the admission orders in the facility from 1/30/2026 through 2/2/2026. Additionally, despite Resident 176's blood glucose readings exceeding 151 mg/dL, Resident 176 did not receive any insulin injections during the four-day period from 1/30/2026 to 2/2/2026. Findings: During a review of the facility's undated policy and procedure (P&P) titled Reconciliation of Medication on Admission, the P&P indicated, Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. Medication reconciliation helps to ensure that medications, routes, and dosages have been accurately communicated to the attending physician and care team. During a review of Resident 176's GACH 1 Patient Discharge Instructions dated 1/30/2026, timestamped at 11:59 AM, the record indicated Resident 176's medication instructions prior to admission to the facility on the same day. The instructions stated, This is your [Resident 176] new current medications list as of 01/30/2026 at 11:59 AM, and further directed, Do not stop taking these medications until told to stop. The list included several medications, including diabetes medications: Alogliptin 12.5 mg oral tablet daily, Glipizide 5 mg oral tablet twice daily before meals, and Insulin Lispro 100 units/mL injectable solution (aggressive correctional scale, subcutaneous) to be administered three times daily before meals and at bedtime. During a review of Resident 176's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with foot ulcer, essential hypertension, and hyperlipidemia. During a review of Resident 176's History and Physical (H&P) signed and dated by Nurse Practitioner (NP) 1 on 1/30/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of facility provided document titled Census List containing Resident 176's name, the document indicated Resident 176 status as active on 1/30/2026 at 2:07 PM. During a review of Resident 176's care plans, an active care plan was identified with a focus on the resident experiencing an unintended interruption of routine diabetic medications during the admission medication reconciliation process. This interruption placed Resident 176 at risk for hyperglycemia and unstable blood glucose levels. The care plan included an initiation date of 2/4/2026. During a review of Resident 176's physician orders upon admission to the facility on [DATE], the orders indicated Resident 176's diabetic medications (Glipizide, Alogliptin, and Insulin Lispro Sliding Scale) were not transcribed in the resident's facility admission orders according to the Discharge Instructions from the GACH. During further review of Resident 176's physician orders dated 1/30/2026, timed at 4:30 PM, the orders indicated to check Resident 176's blood sugar before meals and at bedtime and to call the physician if the resident's blood sugar level is below 60 or greater than 400 for DM. During a review of the Medication Administration Record (MAR) from 1/30/2026 to 1/31/2026, the MAR indicated Resident 176's blood sugar levels ranged from 136 to 267. The MAR further indicated no insulin coverage was administered to the resident according to Discharge (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Instructions from the GACH since the order was not transcribed. During a review of the MAR from 2/1/2026 at 6:30 AM to 2/3/2026 at 11:30 AM, the MAR indicated Resident 176's blood sugar levels ranged from 112 to 280. The MAR further indicated no insulin coverage was administered to the resident according to Discharge Instructions from the GACH since the order was not transcribed. During an interview on 02/02/2026 at 9:30 AM with Resident 176, Resident 176 stated that he was admitted to the facility on [DATE] from GACH 1. Resident 176 reported that facility staff had not administered the diabetic medications he had been taking regularly prior to admission. Resident 176 further stated that when he inquired about receiving his usual diabetic medications one day after admission, the nurse informed him that those medications were not included in the physician's orders. During an interview on 02/04/2026 at 4:46 PM, while reviewing Resident 176's medical record with Registered Nurse (RN 1), RN 1 stated that upon any resident's admission to the facility, the admitting nurse should review the GACH discharge packet, which contains the resident's medications, in order to obtain the discharge medication list from the GACH. If the list does not accompany the resident, the admitting nurse should request it directly from the GACH and inform the admitting physician. During a concurrent review of Resident 176's admission orders dated 01/30/2026, RN 1 confirmed that Resident 176's diabetic medications (Glipizide, Alogliptin, and Insulin Lispro Sliding Scale) were not entered in the resident's admission orders. During an interview on 02/05/2026 at 10:30 AM with Licensed Vocational Nurse (LVN 3), she stated that she was the admitting nurse for Resident 176 on 01/30/2026. LVN 3 explained that upon Resident 176's admission around 2:00 PM, she did not locate the GACH discharge medication list. LVN 3 stated that she reviewed Resident 176's hospital active medication list, communicated those medications to NP 1 and entered the medications she believed were appropriate for admission orders. LVN 3 acknowledged that she only reviewed the GACH active medications and not the GACH discharge orders. LVN 3 further stated that when inputting the orders, she saw blood sugar checks but missed the Insulin Lispro correctional (sliding) scale order listed under the GACH active medications. During the same interview on 02/05/2026 at 10:30 AM, LVN 3 further stated that on 02/03/2026, another nurse informed her that the facility had obtained Resident 176's GACH discharge orders. LVN 3 stated that she reviewed the GACH discharge orders and entered additional medications that were missed on 1/30/2026 admission, including Glipizide and Alogliptin. LVN 3 stated she did not know who obtained the GACH discharge medication orders or why they had not been reviewed and entered into the facility's system when received, instead of being placed in the paper chart. LVN 3 also admitted that she did not inform anyone on 01/30/2026 that the admission orders she entered were based solely on the hospital's active medication list and not the GACH Discharge Orders or Instructions. Additionally, LVN 3 stated that she did not request the discharge orders from the GACH on 1/30/2026, because it was near the end of her shift and she forgot to endorse this task before leaving for the day. During a telephone interview on 2/05/2026 at 4:32 PM with Nurse Practitioner (NP1), NP1 stated he was Resident 176's admitting provider. NP1 stated he was at the facility on 1/30/2026 but could not recall what information, if any, he received from Resident 176's admission nurse on the date Resident 176's admission to the facility on 1/30/2026. NP1 further stated he would expect the facility's licensed nurses to notify him if they did not obtain or review a resident's GACH discharge orders, as he would review the medications to determine if anything needed to be added or clarified. During an interview and record review on 02/10/2026 at 2:00 PM with the facility's Director of Nursing (DON 2), regarding the facility's policy and procedure (P&P) titled Reconciliation of Medication on Admission and Resident 176's medical records, DON 2 stated that LVN 3 did not follow the facility's P&P for medication reconciliation upon Resident 176's admission on [DATE]. DON 2 stated LVN 3 failed to obtain Resident 176's GACH discharge summary and discharge instructions when the GACH discharge orders were not found in Resident 176's GACH records on 01/30/2026 and did not communicate the GACH discharge medications or Resident 176's diabetes management to the admitting physician and/or NP 1.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide the necessary care and services to prevent pressure injury (a skin injury due to prolonged unrelieved pressure and friction) for one of three sampled residents (Resident 21), who was unable to carry out activities of daily living (ADLs) to maintain ADLs mobility and assisted with transferring from bed to chair for two hours as tolerated with pressure relieving cushion as ordered by the physician. This deficient practice had the potential for Resident 21 to develop pressure injury, Findings: During a review of Resident 21's admission Record (AR), the AR indicated that the facility originally admitted Resident 21 on 10/15/2025 with diagnoses including post-laminectomy syndrome (any lingering pain of unknown origin following back surgery), spinal stenosis (the narrowing of one or more spaces within the spinal canal), and hypertension (high blood pressure). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 1/16/2026, the MDS indicated that Resident 21 had intact cognitive function (thought process or decision consistent/reasonable) and was dependent (helper does all the effort) with staff on rolling left and right, sit to lying, and chair/bed-to-chair transfer. During a review of Resident 21's Care Plan (CP) dated 10/16/2025, titled ADL Self Care Performance Deficit related to paraplegia (loss of movement and/or sensation, to some degree, of the legs) spinal stenosis indicated the resident required mechanical aid (specialized devices designed to safely lift, transfer, and reposition patients) with large sling for transfers with two staff. The CP interventions included to provide supportive care, assistance with mobility as needed and document assistance as needed. The CP was updated on 12/12/2025 and added interventions added to transfer Resident 21 to chair for 2 hours as tolerated with pressure relieving cushion. During a review of Resident 21's Physician Orders dated 12/12/2025, the Orders indicated to assist with transferring to chair for two hours as tolerated with pressure relieving cushion. During a review of Resident 21's Flowchart for Activities of Daily Living (ADLs Flowchart) dated from 1/1/2026 to 2/4/2026, the ADLs Flowchart section for Chair/Bed-to-chair transfer indicated Not Applicable or left blank on day, evening, or night shift on all of three shifts. During an observation on 2/5/2026 at 10:10 AM, Resident 21 was lying in bed. In an interview Resident 21 stated, he has not been assisted to get out of bed since last month. In a concurrent interview with Certified Nurse Assistant (CNA) 1 who was at bedside, stated she did not assist Resident 21 to get out of bed because she does not know the level of assistance that Resident 21 required. CNA 1 stated she should have been aware with the level of assistance that Resident 21 required since it was her responsibility to assist the residents to get out of bed. During an interview on 2/5/2026 at 10:40 AM with the Licensed Vocational Nurse (LVN) 3, LVN 3 stated she had not assisted or offered Resident 21 to get out of bed and she does not remember the last time she saw Resident 21 sat on a chair. LVN 3 stated she was not sure if CNA 1 was made aware about the level of assistance that Resident 21 required. LVN 3 stated it was important to assist residents out of bed to promote independence, improve circulation, and lower the risk of developing pressure injury. During an interview on 2/6/2026 at 11:15 AM with the Director of Staff Development (DSD), DSD stated she was responsible for supervising CNAs and ensuring they provide proper care and assistance to residents. The DSD stated CNAs had to know their assignment and they should receive report from previous the nurse from the shift. The DSD further stated CNAs should chart as refuse if resident refused any care and inform charge nurse, instead of checking Not applicable because that can't validate if care or service was offered. The DSD stated it was important to encourage and provide assistance to resident out of bed because it affects their quality of life, prolonged bedrest causes poor circulation and further problems. During a review of the facility's undated, Policy and Procedures (P&P) Activities of Daily Living, the P&P indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with mobility (transfer and ambulation, including walking). The P&P also indicated that interventions to (continued on next page)		

Department of Health & Human Services
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. And the resident's response to interventions will be monitored, evaluated and revised as appropriate.		

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F 0690 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to implement interventions to prevent CAUTIs (catheter-associated urinary tract infections, urinary tract infections caused by the improper use of urinary catheters) as indicated in the facility's policy and procedure and resident's care plan for one out of four sampled residents (Resident 151) with suprapubic catheters (a urinary tube inserted through the lower abdominal wall into the bladder that connects to a bag to collect urine) who was observed on top of resident's bed next to his left leg. This deficient practice placed Resident 151 at an increased risk of developing a urinary tract infection. Findings: During a review of Resident 151's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included neuromuscular dysfunction of the bladder (occurs when nerve damage disrupts communication between the brain, spinal cord, and bladder muscles, causing leaking or retention of urine), muscle weakness, and surgery of the genitourinary system. During a review of Resident 151's History and Physical (H&P), dated 6/28/2025, the H&P indicated that the resident does have the capacity to understand and make decisions. The H&P indicated that the resident had a suprapubic catheter. During a review of Resident 151's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2026, the MDS indicated that the resident has moderately impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (helper does all the effort) on activities such as eating, toileting, bathing, personal hygiene, and rolling in bed from left to right. During a review of Resident 151's physician's orders as of 2/2/2026, the orders included the following orders: Suprapubic [catheter]: Fr (French, a unit of measuring the size of a catheter) with 10 cc (cc or mL, a unit of measuring liquid volume) balloon to drainage bag for diagnosis Neuromuscular dysfunction of bladder, ordered on 1/18/2026. 2. Replace drainage system if disconnections or leakage occur as needed, ordered on 7/5/2025. 3. Monitor suprapubic catheter for urine color, hematuria, odor, and sediments. Notify MD if abnormal every shift for suprapubic catheter use, ordered on 8/17/2025. During a review of Resident 151's care plan for suprapubic catheter, initiated on 11/12/2024, the care plan included a goal for Resident 151 to have no signs and symptoms of urinary tract infection. The care plan also included interventions for staff to place the catheter in proper placement. During a review of Resident 151's care plan for hematuria (presence of blood in the urine), initiated on 1/26/2026, the care plan included a goal for Resident 151 to have no signs and symptoms of urinary tract infection. During an observation and interview on 2/2/2026 at 10:28 AM inside Resident 151's room, Resident 151 was observed lying in bed. Resident 151's catheter bag was observed on top of the bed and next to the resident's left leg. The catheter bag appeared empty. Resident 151 stated he does not know why the catheter bag was next to his leg. Resident 151 stated he does not know who placed the catheter bag on the bed. During a concurrent observation and interview on 2/2/2026 at 10:32 AM with Assistant Minimum Data Set Nurse (AMDSN) inside Resident 151's room, MDSNA stated that Resident 151's catheter bag was on the bed, right next to the resident's leg. AMDSN stated that the catheter bag is not draining properly because it is not below the level of the resident's bladder. AMDSN stated that if catheter bags do not drain properly, the urine could stay in the bladder or back up into the bladder, which could cause a urinary infection. During another concurrent observation and interview on 2/2/2026 at 10:34 AM with AMDSN inside Resident 151's room, AMDSN stated she will place the catheter bag below the level of Resident 151's bladder and hang it on the resident's bed frame. AMDSN placed the catheter bag on the resident's bed rail and approximately 100 mL (milliliter, a unit of measuring liquid volume) of urine drained into the catheter bag. During an interview on 2/2/2026 at 10:36 AM with Treatment Nurse (TN) 1, TN 1 stated she placed Resident 151's catheter bag on the resident's bed because she had recently changed the resident's catheter bag. TN 1 stated she forgot (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rio Hondo Subacute & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 273 E Beverly Boulevard Montebello, CA 90640	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to place the catheter bag below the level of the resident's bladder because she rushed out of the room to attend to her supply cart. TN 1 added that not placing the catheter bag below the level of bladder could place the resident at risk of developing a urinary infection. During an interview on 2/10/2026 at 1:21 PM with the Director of Nursing (DON) 2 regarding the proper placement of a urinary catheter bag, the DON 2 stated that catheter bags must be placed below the bladder to facilitate the flow of urine into the bag. DON 2 stated that if catheter bags are not placed below the bladder, urine would remain in the bladder or flow back into the bladder which could cause a urinary infection. DON 2 further added that placing the catheter bag on the resident's bed is not appropriate because it would not be below the resident's bladder. During a review of the facility's policy and procedure (P&P) titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, revised on 4/2025, the P&P indicated it is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent CAUTIs (catheter-associated urinary tract infections, urinary tract infections caused by the improper use of urinary catheters). The P&P indicated that CAUTI prevention strategies that are to be followed by staff include maintaining unobstructed urine flow such as keeping the drainage bag below the level of the bladder at all times.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that post-dialysis assessments were conducted and documented in the treatment record, including required vital signs (temperature, pulse, respiration, and blood pressure), for one of two sampled residents (Resident 70). This deficient practice had the potential to delay identification of abnormal vital signs, dialysis access site complications, or adverse treatment reactions-such as untreated hypotension, excessive bleeding, or other serious conditions requiring emergency intervention. Findings: During a review of the facility's policy and procedure (P&P) titled Dialysis Care, dated 8/25/2021, the policy indicated its purpose was To provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments. The policy stated, Nursing staff will communicate the following information in writing to the dialysis staff: the resident's current vital signs and any changes of condition specific to the resident with each treatment. The policy further stated, Nursing staff may use the Hemodialysis Communication Record. The nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The provider's dialysis nurse will be responsible for documentation of dialysis treatment. Documentation will be maintained in the resident's medical record. During a review of Resident 70's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure), dependence on renal dialysis (a life-sustaining treatment that acted as an artificial kidney for people with kidney failure), and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 70's Order Listing Report dated 1/12/2026, the Order Listing Report indicated Dialysis: Monday, Wednesday, and Friday - 1 PM transportation. Pick up at 12 PM in the afternoon every Monday, Wednesday, and Friday. During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool) dated 1/14/2026, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident was receiving oxygen therapy and dialysis. During a review of Resident 70's Hemodialysis (HD, a life-sustaining medical treatment that acted as an artificial kidney to clean the blood of resident's with kidney failure) Communication Record dated 1/14/2026, the HD Communication Record did not have the Post HD Treatment section filled out or signed by a licensed nurse. During a review of Resident 70's HD Communication Record dated 1/23/2026, the HD Communication Record did not have the Post HD Treatment section filled out or signed by a licensed nurse. During a review of Resident 70's HD Communication Record dated 1/30/2026, the HD Communication Record did not have the Post HD Treatment section filled out or signed by a licensed nurse. During an interview on 2/10/2026 at 11:40 AM, Licensed Vocational Nurse (LVN) 10 stated that when a resident returns from dialysis, facility staff must take the resident's vital signs and complete the post-dialysis section of the Hemodialysis (HD) Communication Record. LVN 10 stated Resident 70's HD Communication Record was not fully completed but should have been. LVN 10 explained that checking vital signs upon return is important because the resident may come back weak or with low blood pressure. LVN 10 added that failure to assess the resident after dialysis could result in an undetected change in condition. During a concurrent interview and record review of Resident 70's Hemodialysis (HD) Communication Record on 2/10/2026 at 1:10 PM, Director of Nursing (DON) 1 stated the facility's process for residents receiving dialysis was to complete both the pre-dialysis and post-dialysis sections of the HD Communication Record. DON 1 confirmed the post-dialysis section for Resident 70 was not completed but should have been because it contains pertinent information needed to assess the resident and provide interventions as necessary. DON 1 explained that failure to complete the post-dialysis section could result in missing critical changes in condition, such as hypotension (low blood pressure) or bleeding at the dialysis site.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the attending physician visit one of three sampled residents (Resident 21) once every 30 days for the first 90 days after admission. This deficient practice had the potential for poor continuity of care and follow-up on Resident 21's status. Findings: During a review of Resident 21's, admission Record (AR) dated 10/15/2025, the AR indicated Resident 21 was admitted to the facility on [DATE] with the diagnoses of paraplegia (loss of movement and/or sensation to some degree, of the legs), acute kidney failure (loss of kidneys' ability to remove waste and help balance fluids), compression fracture of T5-T6 vertebra (break in a bone in your spine). During a review of Resident 1's History and Physical (H&P) dated 10/16/2025, the H&P indicated the Doctor of Nurse Practitioner (DNP) visited Resident 1 on 10/16/2025 and 1/27/2026. During an interview with the Director of Nurse (DON) 1 and concurrent review of Resident 21's H&P on 2/7/2026 5:35 PM, the H&P indicated the DNP visited Resident 21 on 10/15/2025 and 1/27/2026. DON 1 stated there was no documented evidence that Resident 21's attending physician visited Resident 21 since the resident admitted to the facility and no evidence that Resident 21 was seen by the DNP in November and October 2025. DON 1 stated the DNP completed the H&P for Resident 21 on 10/16/2025 and visited Resident 21 again on 1/27/2026. During an interview on 2/7/2026 at 5:48 PM with Administrator (ADM) 2, ADM 2 stated, Resident 21 was initially visited by the DNP on 10/16/2025 and another visit was conducted on 1/27/2026. The ADM 2 confirmed that the attending physician has not assessed and evaluated Resident 21 since Resident 21 was admitted to the facility.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure medications were prepared and administered according to professional standards of practice and in accordance with physician orders, as required under F755 Pharmacy Services. On 2/5/2026, between 8:30 AM and 8:45 AM, during a medication administration observation for Resident 147, LVN 1 prepared 8.5 milliliters (mL) of Levetiracetam oral solution instead of the prescribed 5 mL. The surveyor intervened prior to administration. In addition, LVN 1 did not follow the physician-ordered G-tube flushing protocol. Required water flushes of 30 mL prior to medication administration and at least 15 mL after each medication were not performed during the administration of Amlodipine, Cholecalciferol, Lisinopril, Multivitamin liquid, and a probiotic capsule. Out of six medication administration opportunities observed, two instances did not follow physician orders: One instance involving preparation of an incorrect dosage of Levetiracetam. One instance involving missed G-tube water flushes for five medications. This deficient practice had the potential to result in inadequate medication delivery, tube occlusion, and adverse medication outcomes. Findings: During a review of the facility's P&P titled, Medication Administration, effective 10/2017, the P&P indicated that medications are administered as prescribed in accordance with good nursing principles and practices. The P&P indicated that medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P titled, Medication Errors, effective 6/28/2022, the P&P indicated that medication error means the administration of medication at the wrong dose. During a review of Resident 147's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included epilepsy (or seizures; involuntary shaking, stiffening, or jerking of limbs caused by uncontrolled electrical activity in the brain), dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, reasoning, and communication), and dysphagia (difficulty in swallowing). During a review of Resident 147's physician's order dated 4/23/2023, the order indicated to flush [Gastrostomy tube (Gtube - a medical device inserted directly into the stomach through the abdomen to deliver nutrition, fluids, and medication)] with 30 ml of water before and after medication administration. During a review of Resident 147's History and Physical (H&P), dated 8/23/2024, the H&P indicated that the resident has fluctuating capacity to understand and make decisions. The H&P indicated that Resident 147 has a diagnosis of seizure disorder. During a review of Resident 147's care plan for medication interaction, initiated on 3/16/2023, the care plan indicated that Resident 147 is at risk for potential medication interaction and adverse reactions. The care plan included interventions for staff to administer medications as prescribed, using appropriate administration techniques, initiated 3/16/2023. During a review of Resident 147's care plan for seizures, initiated on 11/14/2025, the care plan indicated that Resident 147 is at risk for seizure activity. The care plan included interventions for staff to administer medications as ordered by the physician. During a review of Resident 147's Minimum Data Set (MDS, a resident assessment tool), dated 12/31/2025, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a review of Resident 147's physician's orders as of 2/2/2026, the orders included the following medication orders: - Levetiracetam Oral Solution 100 mg/mL, give 5 mL via G-tube every 12 hours for seizure 5 mL = 500 mg, ordered on 9/4/2024. - Amlodipine besylate tablet 10 mg give 10 mg via G-tube one time a day for HTN hold for SBP [systolic blood pressure] [is less than] 110 or HR [heart rate] [less than] 60, ordered on 9/6/2023. - Cholecalciferol tablet 1000 unit, give 1 tablet enterally one time a day for supplement, ordered on 2/8/2023. - Lisinopril tablet 2.5 mg give 1 tablet via g-tube one time a day for HTN hold for SBP [less than] 100 and HR [less than] 60, ordered on 9/6/2023. - Multivitamin liquid (multiple vitamins-minerals), give 15 mL via G-tube one time a day for supplement, ordered on 5/5/2024. - Probiotic oral capsule (saccharomyces boulardii), (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give 500 mg via G-tube two times a day for restoration of normal intestinal flora [or bacteria], ordered on 5/5/2025. During a review of Resident 147's physician's order dated 4/23/2023, the order indicated to flush [G-tube] with 30 ml of water before and after medication administration. During a review of Resident 147's physician's order dated 4/23/2023, the order indicated to flush [G-tube] with at least 15 mL of water after each individual medication is given. During a concurrent interview and record review on 2/5/2026 at 8:21 AM with LVN 1, Resident 147's medication orders were reviewed. LVN 1 stated that Resident 147 has a G-tube and that all of the resident's medications are administered via the G-tube. During an observation on 2/5/2026 at 8:22 AM, LVN 1 was observed preparing medications for Resident 147. LVN 1 placed the resident's medications into individual medication cups and crushed amlodipine, cholecalciferol, and lisinopril before placing them into separate cups. LVN 1 also opened a probiotic capsule for the resident. LVN 1 stated the medications were crushed because they were going to be administered via the resident's G-tube. During a medication pass observation in Resident 147's room and interview on 2/5/2026 from 8:23 AM to 8:25 AM, LVN 1 was observed preparing Resident 147's medications, including the Levetiracetam solution (100 mg/mL). LVN 1 stated that she was going to pour 5 mL of Levetiracetam solution into the medicine cup. LVN 1 held up the medicine cup in the air with her left hand at eye level and, using her right hand, poured the Levetiracetam from a medication bottle into the medicine cup. During the observation, the medication cup indicated that the amount of Levetiracetam poured was greater than 8.5 mL. LVN 1 stated that the medications she prepared, specifically the Levetiracetam, were the correct dosage of 5 mL. During the same medication pass observation and interview on 2/5/2026 at 8:30 AM, LVN 1 stated that she was ready to administer all of Resident 147's prepared medications via G-tube, including the Levetiracetam she had poured into the medicine cup and entered Resident 147's room. During an observation on 2/5/2026 at 8:36 AM inside Resident 147's room, Resident 147 was observed sitting in bed. LVN 1 inserted a syringe into the resident's G-tube and stated that the G-tube is now ready to be used to administer the resident's medications. At 8:37 AM, LVN 1 was observed disconnecting the syringe from Resident 147 and then re-inserted the same syringe without the plunger into the G-tube. LVN 1 stated she has checked Resident 147's G-tube and she will now proceed to administer Resident 147's medications using the syringe and into Resident 147's G-tube. LVN 1 did not verbalize that she flushed Resident 147's G-tube. LVN 1 was also not observed flushing Resident 147's G-tube with 30 mL water as ordered by the physician. During the course of the medication administration observation and interview on 2/5/2026 at 8:38 AM inside Resident 147's room, while holding the syringe that was connected to Resident 147's G-tube, LVN 1 was observed pouring water into the medication cup containing amlodipine. LVN 1 did not verbalize the amount of water added; however, the observed amount appeared to be approximately 10 mL. LVN 1 stated she will now administer the resident's medication, amlodipine. LVN 1 poured the mixture of amlodipine and water into the syringe. The mixture was observed slowly going down into Resident 147's G-tube. LVN 1 did not flush Resident 147's G-tube with at least 15 mL of water after administration of the amlodipine, in accordance with the physician's order. At 8:39 AM, LVN 1 stated she will now administer the resident's cholecalciferol. LVN 1 poured water into the medication cup containing cholecalciferol. LVN 1 did not verbalize the amount of water that was poured into the medication cup. Upon observation, the amount of water appeared to be about 7.5 mL. LVN 1 then grabbed the medication cup with the cholecalciferol and water mixture and poured it into Resident 147's G-tube. LVN 1 did not flush Resident 147's G-tube with at least 15 mL of water after administering cholecalciferol, in accordance with the physician's order. At 8:40 AM, LVN 1 stated that she will now administer probiotic. LVN 1 poured water into the medication cup containing the probiotic. LVN 1 did not verbalize the amount of water that was poured into the medication cup. Upon observation, the amount of water appeared to be about 10 mL. LVN 1 then grabbed the medication cup with the probiotic and water mixture and poured it into Resident 147's G-tube. During the same observation and interview, LVN 1 did not flush Resident 147's G-tube with at least 15 mL of water after administering (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the probiotic, in accordance with the physician's order. At 8:41 AM, LVN 1 stated she will now administer the resident's lisinopril. LVN 1 poured water into the medication cup containing the lisinopril. LVN 1 did not verbalize the amount of water that was poured into the medication cup. Upon observation, the amount of water appeared to be about 10 mL. LVN 1 then grabbed the medication cup with the lisinopril and water mixture and poured it into Resident 147's G-tube. LVN 1 did not flush Resident 147's G-tube with at least 15 mL of water after administering the lisinopril. At 8:42 AM, LVN 1 stated that she will now administer the resident's liquid multivitamin. LVN 1 then grabbed the medication cup with the liquid multivitamin and poured it into Resident 147's G-tube. LVN 1 did not flush Resident 147's G-tube, with at least 15 mL of water in accordance with the physician's order. During the continued observation and interview on 2/5/2026 at approximately 8:45 AM, LVN 1 was observed and verbalized that she was ready to administer the contents of the medicine cup, which contained 8.5 mL of Levetiracetam-more than the ordered dose of 5 mL. At this time, the surveyor intervened and instructed LVN 1 to stop the administration of the incorrect dose of Levetiracetam through Resident 147's G-tube. At 8:46 AM with LVN 1, LVN 1 placed the medicine cup containing Levetiracetam flat on Resident 147's bedside table. During a concurrent inspection of the medicine cup, LVN 1 stated that the medicine cup contained more than the prescribed 5 mL of Levetiracetam, specifically 8.5 mL. LVN 1 further stated that if the surveyor had not intervened, LVN 1 would have administered more than the prescribed dosage to Resident 147. During the same medication administration observation and interview on 2/5/2026 at 8:49 AM inside Resident 147's room, LVN 1 verbalized that she was ready to administer the correct dosage of 5 mL of Resident 147's Levetiracetam. LVN 1 poured the Levetiracetam into Resident 147's G-tube. LVN 1 did not flush Resident 147's G-tube prior to administering Levetiracetam with at least 15 mL of water, in accordance with the physician's order. During an interview on 2/5/2026 at 8:54 AM with LVN 1, she stated that she made a mistake when preparing Resident 147's Levetiracetam because she poured 8.5 mL instead of the prescribed 5 mL. LVN 1 explained that she did not place the medication cup on a level surface prior to pouring the Levetiracetam. LVN 1 stated that she did not recheck the amount of medication in the cup after pouring and immediately before administration. LVN 1 stated that if the surveyor had not intervened, she would have administered more than the prescribed dosage. LVN 1 further acknowledged that administering more than the prescribed dosage is a serious medication error that could cause adverse effects to Resident 147. During the same interview on 2/5/2026 at 8:54 AM with LVN 1, LVN 1 stated she made multiple mistakes while administering Resident 147's medications because she did not flush the resident's G-tube before and in between administering the medications. LVN 1 explained that flushing the G-tube before medication administration is important to prevent clogging and ensure the resident receives the full dose. LVN 1 further stated that flushing between each medication is necessary to prevent medications from mixing in the G-tube, which could cause harmful interactions. During an interview on 2/6/2026 at 12:20 PM with Resident 147, Resident 147 stated she did not know what medications she was prescribed at the facility and how much of each medication she needs to take. During an interview on 2/10/2026 at 1:21 PM with DON 2, DON 2 stated that it is the facility's policy for nurses to administer the correct dosage of medication to residents. DON 2 explained that administering an incorrect dosage, such as more than the prescribed amount, can cause adverse side effects. DON 2 further stated that side effects of anticonvulsant medications such as Levetiracetam include drowsiness, lethargy, nausea, and vomiting. DON 2 emphasized that when preparing liquid medications, nurses should ensure the medication cup is level by placing it on a flat surface, such as the medication cart, before pouring the medication. DON 2 added that holding the medicine cup in the air while pouring is incorrect because the cup could tilt, resulting in an inaccurate measurement of the medication. During the same interview on 2/10/2026 at 1:21 PM with DON 2, DON 2 stated that during medication administration, nurses must flush the resident's G-tube with 30 mL of water or the amount prescribed by the physician. DON 2 added that nurses should also flush the G-tube between each medication administered. DON 2 explained that (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flushing ensures the G-tube does not clog and that the resident receives the full dose of each medication. DON 2 further stated that failure to flush between medications could result in chemical interactions that may change the effects of the medications.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that licensed nursing staff and the attending physician acted upon the Pharmacist Consultant's recommendations identified during the monthly Medication Regimen Review (MRR, a comprehensive evaluation of a resident's medication regimen intended to promote positive outcomes and minimize adverse effects)) for one of two sampled residents (Resident 1). Specifically, the facility did not: Update Resident 1's physician orders to include administration instructions for carvedilol (Coreg) to give with food/meals, as recommended by the pharmacist. Obtain current informed consents for the use of trazodone hydrochloride (HCL) and Ativan, as identified by the pharmacist. These failures had the potential to place Resident 1 at risk for adverse drug effects and violation of resident's rights to be informed of treatments. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and anxiety disorder (a mental health condition marked by excessive, persistent, and uncontrollable worry or fear about everyday situations, going beyond normal nervousness and interfering with daily life, work, and relationships). During a review of Resident 1's Consultant Pharmacist's Medication Regimen Review (MRR) dated 12/1/2025 and 12/17/2025, the MRR indicated for Resident 1 to ensure the informed consent were current for trazodone and Ativan use. The MRR indicated for Resident 1's Coreg order, to add give with food/meals. During a review of Resident 1's Medication Administration Record (MAR) dated 12/1/2025 to 1/31/2025, the MAR indicated the resident received carvedilol, oral tablet 6.25 milligrams (mg, unit of measurement), give one tablet by mouth two times a day for high blood pressure (BP), hold if systolic BP (SBP, the top [higher] number in a blood pressure reading, measuring the maximum force of blood pushing against artery walls when the heart beats and contracts) less than 130 or heart rate less than 60 from 12/2/2025 to 1/31/2025. The MAR did not indicate to give the medication with food or with meals. During a review of Resident 1's Order Summary Report dated 12/2/2025, the Order Summary Report indicated carvedilol, oral tablet 6.25 mg, give one tablet by mouth two times a day for high BP, hold if SBP less than 130 or heart rate less than 60. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 12/5/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident's active diagnoses included dementia, depression, and anxiety disorder. The MDS indicated the resident was receiving antipsychotic, antianxiety, and antidepressant medications. During a review of Resident 1's MRR dated 1/1/2026 and 1/13/2026, the MRR indicated for Resident 1's Coreg order, to add give with food/meals. During a review of Resident 1's History and Physical (H&P) dated 1/4/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Psychotropic Medication Administration Disclosure/Informed Consent Form dated 2/4/2026, the Form indicated Ativan one mg tablet every 12 hours by mouth. The Form indicated a verbal consent was obtained by the Nurse Practitioner (NP, an Advanced Practice Registered Nurse with a graduate degree who provided direct patient care) and Registered Nurse (RN) from Resident 1's Responsible Party (RP). The Form did not include the resident's diagnosis, the duration of how long the resident would be on the medication, or specific observable behaviors indicating the purpose of the medication. During a review of Resident 1's Comprehensive (Complete) Medical Chart, the Comprehensive Medical Chart did not have a Psychotropic Medication Administration Disclosure/Informed Consent Form for trazodone. During an interview on 2/9/2026 at 4:37 PM, the PC stated the facility staff should have followed the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Rio Hondo Subacute & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 273 E Beverly Boulevard Montebello, CA 90640	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations for Resident 1's Coreg medication for better absorption of the medication to take the medication with food or meals. The PC stated if the medication was not given with food or meals, then the resident was not getting the full absorption of the medication and the resident's BP could go up. During an interview on 2/9/2026 at 4:45 PM, the PC stated there should have been consent for Resident 1's medications for Ativan and trazodone to ensure there was no abuse and the guidelines were being followed. The PC stated with these medications, a lot of the time they were used to sedate residents and ensuring that was not happening to the resident was important especially with the resident's dementia diagnosis. The PC stated without consent the facility could not start the medication otherwise the facility would not be following the Department of Health Services (DHS) guidelines. During an interview on 2/10/2026 at 12:52 PM, the Director of Nursing (DON) 1 stated informed consent for trazodone and divalproex should have been in the resident's chart or electronic system. DON 1 stated without proper informed consent the facility staff could not give those medications because the facility staff would not know if the resident agreed with the treatment. DON 1 stated without informed consent the facility could be doing something against the will of the resident and the resident had rights so the facility staff must obtain informed consent. During an interview on 2/10/2026 at 12:56 PM, DON 1 stated the Ativan informed consent was not complete but should have been. DON 1 stated the reason why the resident was on the medication and the duration of how long the resident was to be on the medication should have been on the informed consent. During a concurrent interview and record review of Resident 1's Coreg order and MRR on 2/10/2026 at 10:01 PM, DON 1 stated the facility staff did not follow the Pharmacist Recommendations from the MRR but should have. DON 1 stated if the facility staff did not follow the Pharmacists' recommendations, the resident could have ulcers or stomach issues and pain because giving food with the medication was to protect the stomach. During a review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports dated June 2021, the P&P indicated The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The P&P indicated, Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported to the Director of Nursing, and/or prescriber as appropriate. Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.		