STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO HONDO SUBACUTE & NURSING CENTER	273 E BEVERLY BOULEVARD MONTEBELLO, CA 90640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to report an allegation of resident to resident abuse not later than two hours to the facility's Administrator and to the State appointed agency, law enforcement and the Department for two of nine sampled residents (Residents 4 and 5). This deficient practice had the potential for the facility to under report allegations of abuse, which could lead to failure to investigate alleged abuse in a timely manner. Findings: a. A review of Resident 5's Admission Record indicated the facility originally admitted Resident 5 on 9/21/19 and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 9/28/19, indicated Resident 5 was able to communicate and was cognitively (ability to understand and make decisions' of daily living) intact. A review of Resident 5's Progress Notes dated 10/1/19 at 3:27 p.m., indicated a change in condition has been noted and the symptoms included behavioral symptoms (e.g. agitation, [MEDICAL CONDITION]) on 10/1/19. The note indicated the physician was notified and ordered a psychological evaluation. A review of Resident 5's Progress Notes dated 10/1/19 at 4:18 p.m., indicated the Social Services Designee (SSD) attempted to speak with Resident 5 regarding threats she was making to co-resident (Resident 4). The note indicated Resident 5 referred to Resident 4 as a grumpy [***] and stated she did not talk to Resident 4 and she was not even in the room most of the time. The SSD attempted for a room change but Resident 5 refused to change rooms today but stated she would move tomorrow. The SSD informed Resident 5 that she needed to respect co-resident rights. A review of Resident 5's Progress Notes dated 10/1/19 at 4:19 p.m., indicated Resident 5 was noted with inappropriate behavior towards roommate (Resident 4). Resident 5 was asking to get Resident 4's television remote control but Resident 4 refused to give it. Resident 5 then tried to throw inappropriate words and closed Resident 4's curtain. The note indicated the Residents 4 and 5, did not get along with each other. The note indicated the physician was aware, ordered a psychological evaluation and for Resident 5 to move to another room. A review of Resident 5's Progress Notes dated 10/1/19 at 11:27 p.m., indicated Resident 5 was on monitoring for inappropriate behavior towards roommate (Resident 4). The note indicated Resident 5 refused room transfer and became verbally aggressive however, redirected self once she was left alone. Resident 5 stated she will transfer in the morning. b. A review of Resident 4's Admission Record indicated the facility originally admitted Resident 4 on 4/11/19 and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's MDS dated [DATE], indicated Resident 4 was able to communicate and was cognitively intact. On 10/8/19, the Department received a Report of Suspected Dependent Adult/Elder Abuse dated 10/8/19, indicating Resident 4 claimed she was verbally threatened by Resident 5. Resident 5 allegedly told Resident 4 I will kill you. A review of the facility's investigation dated 10/11/19, indicated on 10/8/19 during the care plan meeting, Resident 4 reported that on 10/2/19, Resident 5 verbally threatened her and told her I will kill you. The investigation indicated per Resident 4, X-ray Technician 1 (X-ray Tech 1) was in the room when the incident occurred. A review of the facility's undated interview with X-ray Tech 1, indicated X-ray Tech 1 heard Resident 5 was borrowing Resident 4's remote control. Resident 4 refused to share her remote and told Resident 5 no, get your own remote. Resident 5 got upset and X-ray Tech 1 intervened and stopped them and reported what he observed to Licensed Vocational Nurse 2 (LVN 2). X-ray Tech 1 denied hearing Resident 5 say I will kill you. During an interview on 11/5/19 at 5:45 p.m., Resident 4 stated, Resident 5 threatened to take Resident 4's TV remote control and kill Resident 4. Resident 4 stated X-ray Tech 1 and another facility staff was there and witnessed the incident. During an interview and concurrent record review on 3/5/2020 at 3:15 p.m., the Administrator and Director of Nursing (DON) stated they were not aware of any incident between Residents 4 and 5 as documented on Resident 5's Progress Notes on 10/1/19. The Administrator stated any staff can report allegations of abuse to the Department and other officials within two hours even when the Administrator was not in the facility. The Administrator and DON stated they found out about the allegation from Resident 4 during the care plan meeting on 10/8/19. A review of facility's policy and procedures titled Abuse Prohibition revised on 7/1/19, indicated employees are designated as mandated reporters and are obligated to immediately report. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a patient. The policy indicated upon receiving information concerning a report of suspected or alleged abuse, the Center Executive Director (CED) or designee will report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. Notify local law enforcement, licensing boards and registries, and other agencies as required. Provide subsequent report to the Department as often as necessary. Initiate an investigation within 24 hours of allegation of abuse that focuses on whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries, if indicated; causative factors and interventions to prevent further injury.
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 interview and record review, the facility failed to follow and clarify the physician's order to check the blood glucose (sugar) level for one of three sampled residents (Resident 1) who was on Basaglar (a long-acting insulin (a hormone that lowers the level of glucose in the blood) used to control high blood sugar) and [MEDICATION NAME] (medication used to control blood sugar levels) once a day. This deficient practice placed Resident 1 at risk for [DIAGNOSES REDACTED] (low blood sugar) by not monitoring Resident 1's blood sugar levels. Findings: A review of the Admission Record indicated the facility admitted the resident on 2/8/2020, with [DIAGNOSES REDACTED]. A review of Resident 1's Medication Review Report for February 2020, indicated a physician's order dated 2/8/2020, to perform fingerstick (pricking finger with a lancet to get a small drop of blood) blood glucose (frequency not specified) and notify the physician if blood sugar is greater than 400 or below 70. A review of Resident 1's care plan dated 2/9/2020, indicated Resident 1 had a [DIAGNOSES REDACTED]. The nursing interventions included to administer hypoglycemic medications as ordered, and educate the resident on the signs and symptoms of hypo/[MEDICAL CONDITION] (low/high blood sugar). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 2/14/2020, indicated the resident was usually able to communicate, cognitively (ability to make decisions of daily living) intact, required limited assistance with eating, extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene, and total assistance with bathing. The MDS indicated Resident 1 had a [DIAGNOSES REDACTED]. During an interview on 3/5/2020 at 1:40 p.m., Resident 1 stated he receives insulin injection and diabetic medication once a day. Resident 1 stated the staff did not check his blood sugar regularly. During an interview and concurrent record review of Resident 1's Medication Administration Records (MARs) on 3/5/2020 at 8:52

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) a.m., the Assistant Director of Nursing (ADON) stated Resident 1's blood sugar level was not being monitored During an interview on 3/5/2020 at 9:15 a.m., Licensed Vocational Nurse 3 (LVN 3) stated she was Resident 1's regular medication nurse. LVN 3 stated Resident 1 had no order for blood sugar monitoring. During an interview on 3/6/2020 at 10:10 a.m., the ADON stated Resident 1 had an order for [REDACTED]. The ADON stated he notified Resident 1's physician yesterday (3/5/2020) that Resident 1's blood sugar level was not being monitored as ordered. The ADON stated he obtained a new order to check Resident 1's blood sugar levels before meals and at bedtime. On a concurrent record review with the ADON, Resident 1's Weights and Vitals Summary, indicated the resident's blood sugar was not monitored from 2/8/2020 to 2/15/2020, and 2/28/2020 to 3/5/2020 when the surveyor identified the discrepancy. A review of the facility's policy and procedures titled Fingerstick Glucose Measurement revised on 11/1/19, indicated verify order and follow physician provider order for insulin administration as ordered and/or physician notification. Document blood glucose level on Medication Administration Record [REDACTED]. According to https://davisplus.fadavis.com/3976/meddeck/pdf/[MEDICATION NAME].pdf, when taking Basaglar, assess for symptoms of [DIAGNOSES REDACTED] such as anxiety, restlessness, tingling, cold sweats, confusion, cool and pale skin, drowsiness, nausea and etc. Monitor blood glucose every six hours during therapy, more frequently in times of ketoacidosis (serious diabetes complication where the body produces excess blood acids) and stress.