STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. Building B. Wing	07/21/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36231 Based on observation, interview and record review, the facility failed to provided treatment to maintain normal bowel movement for one of seven sampled residents (Resident 1). Resident 1 was not provided care according to Resident 1' s care plan, physician order, and facility's policies and procedures by failing to: 1. The Certified Nurse Assistant (CNA) failed to document and report to the charge nurse the lack of BM of Resident 1 for eight (8) days. 2. The facility's electronic system does not allow the CNA's to update changes in BM episodes. 3. The Licensed Vocational Nurse (LVN) did not give the standing orders to treat Resident 1 for constipation. 4. The physician was not notified of Resident 1's lack of BM for 5 days from [DATE] to [DATE]; 6 days from [DATE] to [DATE]; and 8 days from [DATE] to [DATE]. The deficient practice resulted in Resident 1 large feculent matter output from a nasogastric tube (NGT, a flexible tube or plastic or rubber that passes through the nose down through the esophagus [tube were food passes] at the hospital on [DATE]. Resident 1 had died on [DATE] with cause of death included sepsis (life-threatening complication of infection). On [DATE] at 8:34 p.m., an Immediate Jeopardy was called, (IJ, a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death of a resident) in the facility. During a teleconference with Director of Nursing (DON) and in the presence of Licensed Vocational Nurse 4 (LVN 4), were notified of the findings regarding the facility's failure to identify residents Bowel Movement (BM) program not implemented, gaps on communication, and monitoring residents with no BM. On [DATE] at 3:44 p.m., the Administrator (ADM), provided an acceptable plan of action (POA) that included the following summarized actions: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The identification of other residents potentially affected by the deficient practice identified. On [DATE], the medical records and/or designee conducted BM documentation audit of all residents for the last two weeks to identify gaps and records of no BM in the last three (3) days. The facility identified twenty-three (23) residents with no record of BM in the last 3 days. Residents identified were assessed by a licensed nurse, on [DATE] and provided bowel regimen as ordered. 2. A systemic changes of all current and new admit residents will develop a bowel protocol per physician's order. 3. The Regional Nurse Resource (RNR), DON and or designee initiated an in-service education on [DATE]to licensed nurses to be completed by [DATE]regarding the following (a) BM observation and monitoring, (b) BM assessment and notification, (c) BM regimen protocols and administrations, (d) BM documentation and updating electronically when there is changes. 4. The RNR, DON and or designee initiated an in-service education on [DATE] to CNA's to be completed by [DATE] regarding the following: (a) BM observation and monitoring related to frequency, consistency and size, (b) BM episodes reporting to licensed nurses and (c) BM documentation and updating electronically when changes occurs. 5. Medical records and or designee will conduct a daily BM audit Monday to Friday to capture any sign of gaps or omission and findings will be provided to the DON, ADON, Registered Nurse (RN) supervisors and or designee for follow up interventions an discussions during daily stand up meeting Monday to Friday. 6. Licensed nurses and or designee will review the BM episode through the CNA's report, point click care (PCC) dashboard and from task bar in resident's profile every shift and as needed. Licensed nurses will assess and initiate change of condition (COC) notifying the physician for further interventions and responsible party (RP) for any reported and or identified residents with no BM for the last seventy-two (72) hours. 7. CNA's will create a new BM entry should there be a BM after the CNA has already documented to update current information of resident BM and report to their respective charge nurse for further intervention and evaluation. 8. Director of Staff Development (DSD) will conduct activities of daily living (ADL) record review specific to BM episodes daily Monday to Friday to capture any omissions and or with no BM episodes. Findings will be discussed during daily stand up meeting Monday to Friday for further interventions, License nurses will review BM records for the last seven (7) days and document summary during their licensed weekly summary notes. 9. The monitoring process included DON and or designee will present and discuss BM audit findings utilizing medical records audit tool forms to the Quality Assurance Committee (QAC) monthly for three (3) months for further recommendations and will re-evaluate thereafter for compliance. The DON will be responsible for the compliance review and follow up. On [DATE] at 6:54 p.m., after verifying and confirming on-site the implementation of the facility's immediate corrective actions within the POA, the IJ was lifted in the presence of the ADM and DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross reference F 726 and F 760. Findings: A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility, on [DATE], and was readmitted on [DATE], with the diagnoses that included diabetes mellitus, (DM, a disease that blood sugar is uncontrolled and high), cerebral infarction (stroke, narrowing or blockage in the arteries supplying blood and oxygen to the brain) and Parkinson's Disease (PD, progressive nervous system disorder that affects movement including tremors [involuntary shaking]). A review of Resident 1's Minimum Data Set (MDS, a resident assessment and care plan screening tool), dated [DATE], indicated Resident 1 had severe impairment in cognitive skills (the resident ability to understand, remember and make decisions). Resident 1 required one-person extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff with bed mobility, transfer, eating, toilet use, and personal hygiene. Resident 1 bowel and bladder assessment indicated no episodes of continence (ability to control) in voiding (urinating) and BM. A review of Resident 1's History and Physical (H & P), dated [DATE], indicated Resident 1 general appearance was chronically ill. Resident 1 had a fluctuating capacity to understand and make decisions. A review of Resident 1's care plan, titled Resident exhibits or is at risk for GI symptoms or complication related to constipation, created on [DATE] and reviewed date [DATE], indicated interventions that included the following: licensed nurse to administer medications as ordered, observe for effectiveness and side effects, report to the resident's physician, assess signs and symptoms for constipation, provide a bowel regimen, utilize pharmacologic (medication treatment) agents as appropriate such as laxatives and stool softeners (medication that helps relieve constipation), and document the effectiveness. The listed goals were the following: resident would not develop GI complications for 90 days and the resident would pass a soft stool every 1 to 2 days. A review of Resident 1's ADL, indicated on the following dates that Resident 1 did not have any BM: a. [DATE] to [DATE] (5 days) b. [DATE] to [DATE] (6 days) c. [DATE] to ,d+[DATE] (8 days) A review of Resident 1's physician's Order Recap Report (ORR) for the month of ,d+[DATE], indicated the physician ordered the following PRN medications for bowel management: 1. Dulcolax suppository (a stool softener given rectally) 10 milligrams (mg, a unit of measurement) every 24 hours (hrs.) PRN for constipation, initially ordered on [DATE] and reordered on [DATE] (readmitted). 2. Fleet enema (works by increasing water in the intestine to hydrate and soften the stool to help produce a bowel movement given rectally) 7 to 19 grams (gm) every 24 hrs. PRN for constipation if Dulcolax suppository is not effective, initially ordered on [DATE] and reordered on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Milk of Magnesia (MOM, used for a short time to treat occasional constipation) 400 mg give 30 milliliter (ml) by mouth (PO) PRN at bedtime if no BM in 3 days, initially ordered on [DATE] and reordered on [DATE]. 4. Miralax powder (increases frequency of BMs and softens the stool) give 17 gm PO with 4 to 8 ounces (oz) of fluid PRN if no BM in past 72 hrs., ordered on [DATE]. A review of Resident 1's physician's ORR for the month of ,d+[DATE], indicated the physician ordered the following medications for the resident to receive routinely: 1.Senna 8.6 mg give 2 tablets at bedtime for constipation, hold for loose stool (watery BM), initially ordered on [DATE] and reordered on [DATE]. 2.Glycolax Powder (same as Miralax, increases frequency of BMs and softens the stool) give 17 gm PO one time a day (QDay) for constipation (mix in 4 to 8 oz. of liquid) and hold for loose stool, initially ordered on [DATE]. A review of Resident 1's Medication Administration Record (MAR) for the month of ,d+[DATE], indicated the facility did not administer Resident 1 any PRN medications to help him have a BM. A review of Resident 1's physician's Progress Note, dated [DATE], indicated Resident's 1 abdomen was soft and non-tender. A review of Resident 1's Medication Review Report (MRR), dated [DATE], indicated the physician ordered initially on [DATE] the following PRN laxative medications: 1.MOM 30 ml PO every 24 hrs. PRN if no BM in past 72 hrs. 2.Dulcolax suppository 10 mg rectally every 24 hrs. PRN if MOM was not effective. 3.Fleet enema 7 to 19 gm/118 ml insert rectally every 24 hrs. PRN if Dulcolax suppository was not effective. 4.Miralax 17 gm PO every 24 hrs. PRN for constipation if the resident has not had a BM in past 72 hrs. A review of Resident 1's MAR, dated ,d+[DATE], indicated the facility did not administer Resident 1 any PRN laxative medications as ordered between the dates of [DATE] to [DATE]. A review of Resident 1's nurse's Progress Notes dated from [DATE] to [DATE], there were no documentation indicating that the facility notified Resident 1's physician regarding the resident not having any BM or having constipation. A review of Resident 1's Situation Background Assessment and Review (SBAR) Communication Form, dated [DATE], indicated Resident 1 had a blood pressure (BP) of ,d+[DATE] (critical high, normal level less than ,d+[DATE]), pulse rate 114 (PR, normal rate 60 to 100 beats per minute), and pulse oximetry of 85% (O2 sat, a saturation level of blood oxygen, normal level 95% to 100%). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's nurse's Progress Notes, dated [DATE] 1:20 p.m., the notes indicated that a CNA (unknown name) reported that Resident 1 had refused lunch and did not appear to be himself. The note indicated that Resident 1's O2 sat was 80 % on room air (no oxygen supplement) and placed on 5 liters (L) via nasal cannula (NC, a lightweight tube with one end split into two prongs which are placed in nostrils to deliver oxygen). RN 1 documented that Resident 1's O2 sat only improved to 83%. Resident 1 was the placed on 15 L via a non-rebreather mask (NRB, a device used to deliver a high oxygen concentration during emergency). Resident 1 was transferred to a General Acute Care Hospital (GACH) for further evaluation. A review of Resident 1's GACH Emergency Department (ED) notes, dated [DATE] at 5:28 p.m., indicated the GACH admitted Resident 1 to the intensive care unit (ICU) for a large bowel obstruction, septic shock (widespread infection causing organ failure and dangerously low blood pressure), and pneumonia (a lung infection). A review of Resident 1's GACH radiology (a branch of medicine that uses imaging technology to diagnose and treat disease) report, dated [DATE], a Computerized Tomography Angiogram (CTA, series of x-ray angles using a computer to provide detailed picture of body organs) chest, CT abdomen (stomach), and pelvic (basin shape bone that protects abdominal organs), indicated the following impression: 1.A bilateral lower lobe atelectasis (collapsed lungs) and/or pneumonia, 2.Severe fecal impaction (severe bowel condition in which a hard, dry mass of stool becomes stuck in the colon or rectum (anus) suspicious for stercoral colitis (rare inflammatory form of colon infection that occurs when impacted fecal materials leads to distention of the colon and eventually fecaloma [hard feces] formation). 3.Associated large bowel obstruction with diffuse colonic distention (build-up of gas or fluid) in the cecum (pouch connecting the small and large in intestines) measuring up to 10 centimeter (cm) in diameter. Diffusely dilated (wider in diameter size) small bowel loops are likely secondary to the large bowel obstruction. A review of Resident 1's GACH emergency room (ER) Inpatient Consult notes, dated [DATE], indicated Resident 1 had a Code Blue (hospital emergency code used to describe a critical status of a patient). The notes indicated Resident 1 was admitted for sepsis with GI source with possible obstruction as patient had a large feculent (waste matter) output from a nasogastric tube (NGT, a flexible tube or plastic or rubber that passes through the nose down through the esophagus [tube were food passes] and into the stomach), and surgery was considered a possibility. A review of Resident 1 Certificate of Death, dated [DATE] at 1:15 p.m., indicated Resident 1's cause of death was acute hypoxic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide), sepsis, and pneumonia. During a telephone interview on [DATE] at 1:57 p.m., LVN 1 stated she was familiar and took of Resident 1 but could not recall giving any laxatives in the past. LVN 1 stated Resident 1 was incontinent of BM. LVN 1 stated generally CNA staff would give report to her at the end of the shift for that day on BM status. LVN 1 added and stated if during stand up meeting a resident was reported of no BM, she would give PRN and if no result, she would call the physician. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:15 p.m., CNA 1 stated she was familiar and had took care of Resident 1 in the past. CNA 1 stated she took care of Resident 1 on [DATE] the day Resident 1 was transferred to the hospital. CNA 1 stated that morning, Resident 1 was not acting his usual behavior. CNA 1 stated Resident 1's face looked different but did not look like he was in pain. CNA 1 stated Resident 1 did not finish his breakfast tray and had a small BM. CNA 1 stated she reported her observation to her charge nurse unable to recall the charge nurse name. During a telephone interview on [DATE] at 2:25 p.m., CNA 2 stated she took care of Resident 1 on and off in , d+[DATE] and ,d+[DATE]. CNA 2 unable to recall Resident 1 BM consistency. CNA 2 stated Resident 1 was incontinent of bladder and BM. During a telephone interview and concurrent record review of Resident 1's ADL record, on [DATE] at 8:55 a. m., the DSD verified and stated CNA staffs' ADL entries for [DATE] to [DATE], indicated Resident 1 had no BM for 8 days. The DSD stated she was not aware of or no report from CNA regarding Resident 1 had BM issues. The DSD verified and stated Resident 1's ,d+[DATE] MAR did not indicate PRN laxatives was administered. During a random telephone interview on [DATE] at 10:28 a.m., CNA 3 stated she documents on ADL resident's bladder and bowel toileting early morning or at 12 p.m. unable to recall dates. CNA 3 stated she would give report at the end of the shift to the licensed nurse if resident had no BM. CNA 3 added and stated the computer gives an alert box in the ADL to those residents who had not have BM for 2 to 3 days and during stand up meeting from the outgoing licensed nurse. During a telephone interview and concurrent record review of Resident's 1 ADL records, on [DATE] at 12 p. m., the DON verified and stated there had been an issue in the past that CNA staff documented early and once the record were saved in the computer, it could not be changed or altered. The DON stated if the resident had a BM towards the end of the shift, the CNA had to report it to the licensed nurse. The DON stated the licensed nurse would document the BM on their progress notes. The DON stated he was not sure how would the computer picked up when licensed nurse documented in narrative regarding resident's BM. The DON stated Resident 1 listed laxative PRN medications were standing orders (a prescribed order in place permanently or until changed or cancelled). During a telephone interview and concurrent record review on [DATE] at 8:30 a.m., the DSD verified and stated the CNA staff did not document any BM entries for 5 days (from [DATE] to [DATE]) and 6 days (from [DATE] to [DATE]). The DSD also stated she was not aware of Resident 1 not having any BM or the CNA staff was not reporting that Resident 1 did not have any BM on those dates ([DATE] to [DATE] and [DATE] to [DATE]). The DSD also verified and stated ,d+[DATE] MAR did not indicate Resident 1 was given PRN laxatives. During a telephone interview on [DATE] at 9:20 a.m., LVN 2 stated the facility's process was that the CNA staff would report to the charge nurse if the resident had no BM during the shift. LVN 2 stated the facility's licensed nurse would know which residents did not have a BM in the last three days through a dashboard (a computerized generated resident list). LVN 2 stated if a resident had no BM in the last three days, he would give the PRN laxative medication as ordered. LVN 2 stated if in 1 to 2 hours the laxative was not effective, he would call the resident's physician. LVN 2 stated he took care of Resident 1 in [DATE] but could not recall giving PRN laxative medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 7:10 p.m., LVN 3 stated she could not recall Resident 1. LVN 3 stated she would normally ask the CNA staff assigned to her residents if the residents had a BM at the end of the shift and documented in her nurse's notes. LVN 3 stated she would check the resident's profile task and or dashboard for residents who had no BM for 3 days. LVN 3 stated she does not check residents ADL because it had the same information. LVN 3 stated if the resident had no BM for 2 to 3 days, she would give the PRN laxative medication, wait for 1 to 2 hours, and if the resident still had no BM, she would call the resident's physician. During a telephone interview on [DATE] at 1:45 p.m., LVN 4 stated regularly worked in Station 4 and at times covers Station 3 where Resident 1 was located. LVN 4 stated she could not recall Resident 1. LVN 4 stated she does weekly assessment on assigned resident's and recollected a question resident last BM history. During another interview on [DATE] at 6:10 p.m., LVN 4 stated she was able to monitor residents with bowel incontinence and residents who have not had BM during her shift through computer. A review of the facility's Abuse Prohibition policy, indicating effective date [DATE] and revised date [DATE]. The policy indicated, Centers prohibits abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all resident. A review of the facility's P & P titled, Continence Management, reviewed date [DATE], indicated a bowel incontinence assessment would be completed if the resident was incontinent upon admission or readmission and with a change in condition or change in continence status. A continence status would be reviewed quarterly and with significant changes as part of the nursing assessment. The purpose of the policy and procedure was to provide an appropriate treatment and services for residents who were incontinent of bowel to restore as much bowel function as possible. A review of the facility's P & P titled, Notification of Change in Condition, effective date [DATE] and revised on [DATE], indicated the facility must immediately inform the resident and consult with the resident's physician when there was a significant change in the resident's physical status and/or a need to alter treatment significantly (that was a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). A review of facility's P & P titled Standing Order, effective date [DATE] and revised on [DATE], indicated standing orders may be used for the following but not limited to constipation, pain, and weekly skin checks. If a standing order had not been used within 90 days, it would be reviewed with the physician for continued use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36231 Based on observation, interview, and record review the facility's Certified Nursing Assistants (CNAs) and licensed nurses failed provided care and services in accordance to professional standard of practice and resident's plan of care for one of seven sampled residents (Resident 1). 1.The CNA failed to report Resident 1's no [NAME] movement (BM) for many days. 2. The licensed nurses failed to review Resident 1's Activity of Daily Living (ADL the tasks of everyday life) records for signs of constipation. 3.The licensed nurses failed to follow Resident 1's plan of care. 4.The licensed nurses failed to follow and implement Resident 1's physicians as needed (PRN) laxative (medication to loosen stools) and increase bowel movements) orders. 5. The licensed nurses failed to notify the physician when Resident 1 had no BM for many days. The deficient practice resulted in Resident 1 not receiving the appropriate assessment and treatment for constipation. Resident developed to bowel obstruction (blockage of the small or large intestine that keeps food, liquid, gas, and stool from moving through the intestines in a normal way). Resident 1 died , on [DATE], with cause of death included sepsis (life-threatening complication of infection). Findings: A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility, on [DATE], and was readmitted on [DATE], with the diagnoses that included diabetes mellitus, (DM, a disease that blood sugar is uncontrolled and high), cerebral infarction (stroke, narrowing or blockage in the arteries supplying blood and oxygen to the brain) and Parkinson's Disease (PD, progressive nervous system disorder that affects movement including tremors [involuntary shaking]). A review of Resident 1's Minimum Data Set (MDS, a resident assessment and care plan screening tool), dated [DATE], indicated Resident 1 had severe impairment in cognitive skills (the resident ability to understand, remember and make decisions). Resident 1 required one-person extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff with bed mobility, transfer, eating, toilet use, and personal hygiene. Resident 1 bowel and bladder assessment indicated no episodes of continence (ability to control) in voiding (urinating) and BM. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's care plan, titled Resident exhibits or is at risk for GI (gastro intestinal, affecting, or including both stomach and intestine) symptoms or complication related to constipation, created [DATE] and reviewed date [DATE], indicated interventions that included the following: licensed nurse to administer medications as ordered, observe for effectiveness and side effects, report to the resident's physician, assess signs and symptoms for constipation, provide a bowel regimen, utilize pharmacologic agents as appropriate such as laxatives and stool softeners, and document the effectiveness. The listed goals were the following: resident would not develop GI complications for 90 days and the resident would pass a soft stool every 1 to 2 days. A review of Resident 1's ADL, indicated on the following dates that Resident 1 did not have any BM: a. [DATE] to [DATE] (5 days) b. [DATE] to [DATE] (6 days) c. [DATE] to ,d+[DATE] (8 days) A review of Resident 1's physician's Order Recap Report (ORR) for the month of ,d+[DATE], indicated the physician ordered the following PRN medications for bowel management: 1. Dulcolax suppository (a stool softener given rectally) 10 milligrams (mg, a unit of measurement) every 24 hours (hrs.) PRN for constipation, initially ordered on [DATE] and reordered on [DATE] (readmitted). 2. Fleet enema (works by increasing water in the intestine to hydrate and soften the stool to help produce a bowel movement given rectally) 7 to 19 grams (gm) every 24 hrs. PRN for constipation if Dulcolax suppository is not effective, initially ordered on [DATE] and reordered on [DATE]. 3. Milk of Magnesia (MOM, used for a short time to treat occasional constipation) 400 mg give 30 milliliter (ml) by mouth (PO) PRN at bedtime if no BM in 3 days, initially ordered on [DATE] and reordered on [DATE]. 4. Miralax powder (increases frequency of BMs and softens the stool) give 17 gm PO with 4 to 8 ounces (oz) of fluid PRN if no BM in past 72 hrs., ordered on [DATE]. A review of Resident 1's physician's ORR for the month of ,d+[DATE], indicated the physician ordered the following medications for the resident to receive routinely: 1. Senna 8.6 mg give 2 tablets at bedtime for constipation, hold for loose stool, initially ordered on [DATE] and reordered on [DATE]. 2. Glycolax Powder (same as Miralax) 17 gm PO QDay for constipation and hold for loose stool, initially ordered on [DATE]. A review of Resident 1's Medication Administration Record (MAR) for the month of ,d+[DATE], indicated the facility did not administer Resident 1 any PRN medications to help him have a BM. (continued on next page)

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

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's Medication Review Report (MRR). dated [DATE], indicated the physician ordered initially on [DATE] the following PRN laxative medications: 1. MOM 30 ml PO every 24 hrs. PRN if no BM in past 72 hrs. 2. Dulcolax suppository 10 mg rectally every 24 hrs. PRN if MOM was not effective. 3. Fleet enema 7 to 19 gm/118 ml insert rectally every 24 hrs. PRN if Dulcolax suppository was not effective. 4. Miralax 17 gm PO every 24 hrs. PRN for constipation if the resident has not had a BM in past 72 hrs. A review of Resident 1's MAR, dated ,d+[DATE], indicated the facility did not administer Resident 1 any PRN laxative medications as ordered between the dates of [DATE] to [DATE]. A review of Resident 1's Progress Notes, dated from [DATE] to [DATE], there were no documentation indicating that the facility notified Resident 1's physician regarding the resident not having any BM or having constipation. A review of Resident 1's GACH Emergency Department (ED) notes, dated [DATE] at 5:28 p.m., indicated the GACH admitted Resident 1 to the intensive care unit (ICU, a designated area of a hospital facility that is dedicated to the care of patients who are seriously ill) for a large bowel obstruction, septic shock (widespread infection causing organ failure and dangerously low blood pressure), and pneumonia (a lung infection). A review of Resident 1 Certificate of Death, dated [DATE] at 1:15 p.m., indicated Resident 1's cause of death was acute hypoxic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide), sepsis, and pneumonia. During a telephone interview on [DATE] at 1:57 p.m., LVN 1 stated she was familiar and took of Resident 1 but could not recall giving any laxatives in the past. LVN 1 stated Resident 1 was incontinent of BM. LVN 1 stated generally CNA staff would give report to her at the end of the shift for that day on BM status. LVN 1 added and stated if during stand up meeting a resident was reported of no BM, she would give PRN and if no result, she would call the physician. During a telephone interview and concurrent record review of Resident 1's ADL's he tasks of everyday life), record, on [DATE] at 8:55 a.m., the DSD verified and stated CNA staffs' ADL entries for [DATE] to [DATE], indicated Resident 1 had no BM for 8 days. The Director of Staff Development (DSD) stated she was not aware that Resident 1 had BM issues. The DSD added and stated Resident 1's ,d+[DATE] MAR did not indicate PRN laxatives was administered. During a telephone interview on [DATE] at 10:28 a.m., CNA 3 stated she documents on ADL resident's bladder and bowel toileting early morning or at 12 p.m. CNA 3 stated she would give report to the licensed nurse if resident had no BM. CNA 3 stated the documentation on the facility's computerized health care record gives an alert box in the ADL if resident had no BM for 2 to 3 days and during stand up meeting report from the outgoing licensed nurse. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview and concurrent record review, on [DATE] at 12 p.m., the Director of Nursing (DON) verified and stated there had been an issue in the past that CNA staff documented early and once the record were saved in the facility's computerized health care record the health care records could not be changed or altered. The DON stated if the resident had a BM towards the end of the shift, the CNA had to report it to the licensed nurse. The DON stated the licensed nurse would document the BM on their progress notes. The DON stated he was not sure how would the computer picked up when licensed nurse documented in narrative regarding resident's BM. The DON stated Resident 1 listed laxative PRN medications were standing orders. During a telephone interview and concurrent record review, on [DATE] at 8:30 a.m., the DSD verified and stated the CNA staff did not document any BM entries for 5 days (from [DATE] to [DATE]) and 6 days (from [DATE] to [DATE]). The DSD also stated she was not aware of Resident 1 not having any BM or the CNA staff was not reporting that Resident 1 did not have any BM on those dates ([DATE] to [DATE] and [DATE] to [DATE]). The DSD also verified and stated ,d+[DATE] MAR did not indicate Resident 1 was given PRN medication. During a telephone interview on [DATE] at 9:20 a.m., Licensed Vocational Nurse 2 (LVN 2) stated the facility's process was that the CNA staff would report to the charge nurse if the resident had no BM during the shift. LVN 2 stated the facility's licensed nurse would know which residents did not have a BM in the last three days through a dashboard (a computerized generated resident list). LVN 2 stated if a resident had no BM in the last three days, he would give the PRN laxative medication as ordered. LVN 2 stated if in 1 to 2 hours the laxative was not effective, he would call the resident's physician. LVN 2 stated he took care of Resident 1 in [DATE] but could not recall giving PRN laxative medication. During a telephone interview, on [DATE], at 7:10 p.m., LVN 3 stated she could not recall Resident 1. LVN 3 stated she would normally ask the CNA staff assigned to her residents if the residents had a BM at the end of the shift and would document in her nurse's note. LVN 3 stated if the resident had no BM for 2 to 3 days, she would give the PRN laxative medication, wait for 1 to 2 hours, and if the resident still had no BM, she would call the resident's physician. During a telephone interview on [DATE] at 1:45 p.m., LVN 4 stated regularly worked in Station 4 and at times covers Station 3 where Resident 1 was located. LVN 4 stated she could not recall Resident 1. LVN 4 stated she does weekly assessment on assigned resident's and recollected a question resident last BM history. During another interview, on [DATE] at 6:10 p.m., LVN 4 stated she was able to monitor residents with bowel incontinence and residents who had not had BM during her shift through computer (point click care - point of care [PCC-POC], a mobile-enable application that runs on wall-mounted kiosks or mobile devices that enable care staff to document ADL at or near the POC to help improve accuracy and timeliness of documentation) dashboard. A review of P & P titled Continence Management, reviewed date [DATE], indicated daily toileting activity were recorded on ADL flowsheet or in the Point Click Care (PCC) and the used of absorbent product. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA's position summary titled Genesis Healthcare Job Description: Centers, revised date [DATE], indicated the CNA was under the direction of a licensed nurse, delivers efficient and effective nursing care while achieving positive clinical outcomes and patient/family satisfaction. The CNA performed various care activities and related non-profession services essential to caring for personal needs and comfort of patients. The responsibilities included assisting patient in a manner conductive ADL; records patient's oral intake and output; uses PCC-POC according to the business process; and reports change in patient condition, patient/family concern or complaints to charge nurse and/or supervisor. A review of LVN's position summary titled Genesis Healthcare Job Description: Centers, revised date [DATE], indicated the LVN was under the direction of the nursing supervisor, unit manager, or Center Nurse Executive (CNE, nurse leader), the charge nurse - LVN ensured the delivery of efficient and effective nursing while achieving positive outcomes and patient/family satisfaction. The charge nurse - LVN managed patient care and collaborated with the nursing team and other disciplines, patients and families to ensure the development of effective plans of care. The LVN's responsibilities included communication between licensed staff and CNA's during and between shifts; participated in shift to shift communication between incoming and outgoing nursing staff; ensured the physician orders were followed as prescribed; and ensures that patient's attending physician and family or responsible party were promptly notified of any significant change in the patient's health condition. A review of DSD position summary titled Genesis Healthcare Job Description: Centers, revised date [DATE], indicated the DSD was responsible for planning, organizing and delivering new hire orientation and in-service education in accordance with current federal, state and local standards guidelines and regulations that govern the facility. The DSD may be directed, by the Administrator and the DON, to ensure that employees were adequately trained in order to provide the highest degree of quality care. The DSD responsibilities included coordination in completion of competency skill checklists as requested for CNA's, supports, teaches, and monitors facility employees for compliance with policies and procedures.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36231 Based on observation, interview and record review, the facility failed to ensure Resident 1 was free of significant pattern of medication omission for one of seven sampled residents (Resident 1). On [DATE] to [DATE] (5 days), [DATE] to [DATE] (6 days) and [DATE] to [DATE] (8 days), Resident 1 as needed (PRN) medication for constipation and was not administered medications as ordered by Resident 1's physician. The deficient practice resulted in Resident's 1 not having a regular bowel movement (BM). Resident developed to bowel obstruction (blockage of the small or large intestine that keeps food, liquid, gas, and stool from moving through the intestines in a normal way). Resident 1 died , on [DATE], with cause of death included sepsis (life-threatening complication of infection). Findings: A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility, on [DATE], and was readmitted on [DATE], with the diagnoses that included diabetes mellitus, (DM, a disease that blood sugar is uncontrolled and high), cerebral infarction (stroke, narrowing or blockage in the arteries supplying blood and oxygen to the brain) and Parkinson's Disease (PD, progressive nervous system disorder that affects movement including tremors [involuntary shaking]). A review of Resident 1's Minimum Data Set (MDS, a resident assessment and care plan screening tool), dated [DATE], indicated Resident 1 had severe impairment in cognitive skills (the resident ability to understand, remember and make decisions). Resident 1 required one-person extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff with bed mobility, transfer, eating, toilet use, and personal hygiene. Resident 1 bowel and bladder assessment indicated no episodes of continence (ability to control) in voiding (urinating) and BM. A review of Resident 1's care plan, titled Resident exhibits or is at risk for GI (gastro intestinal, affecting, or including both stomach and intestine) symptoms or complication related to constipation, created [DATE] and reviewed date [DATE], indicated interventions that included the following: licensed nurse to administer medications as ordered, observe for effectiveness and side effects, report to the resident's physician, assess signs and symptoms for constipation, provide a bowel regimen, utilize pharmacologic agents as appropriate such as laxatives and stool softeners, and document the effectiveness. The listed goals were the following: resident would not develop GI complications for 90 days and the resident would pass a soft stool every 1 to 2 days. A review of Resident 1 Certificate of Death, dated [DATE] at 1:15 p.m., indicated Resident 1's cause of death was acute hypoxic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide), sepsis (infection), and pneumonia (lung infection). A review of Resident 1's ADL, indicated on the following dates that Resident 1 did not have any BM: a. [DATE] to [DATE] (5 days) b. [DATE] to [DATE] (6 days) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. [DATE] to ,d+[DATE] (8 days) A review of Resident 1's physician's Order Recap Report (ORR) for the month of ,d+[DATE], indicated the physician ordered the following PRN medications for bowel management: 1. Dulcolax suppository (a stool softener given rectally) 10 milligrams (mg, a unit of measurement) every 24 hours (hrs.) PRN for constipation, initially ordered on [DATE] and reordered on [DATE] (readmitted). 2. Fleet enema (works by increasing water in the intestine to hydrate and soften the stool to help produce a bowel movement given rectally) 7 to 19 grams (gm) every 24 hrs. PRN for constipation if Dulcolax suppository is not effective, initially ordered on [DATE] and reordered on [DATE]. 3. Milk of Magnesia (MOM, used for a short time to treat occasional constipation) 400 mg give 30 milliliter (ml) by mouth (PO) PRN at bedtime if no BM in 3 days, initially ordered on [DATE] and reordered on [DATE]. 4. Miralax powder (increases frequency of BMs and softens the stool) give 17 gm PO with 4 to 8 ounces (oz) of fluid PRN if no BM in past 72 hrs., ordered on [DATE]. A review of Resident 1's physician's ORR for the month of ,d+[DATE], indicated the physician ordered the following medications for the resident to receive routinely: 1. Senna 8.6 mg give 2 tablets at bedtime for constipation, hold for loose stool, initially ordered on [DATE] and reordered on [DATE]. 2. Glycolax Powder (same as Miralax) 17 gm PO once a day for constipation and hold for loose stool, initially ordered on [DATE]. A review of Resident 1's Medication Administration Record (MAR) for the month of ,d+[DATE], indicated the facility did not administer Resident 1 any PRN medications to help him have a BM. A review of Resident 1's Medication Review Report (MRR). dated [DATE], indicated the physician ordered initially on [DATE] the following PRN laxative medications: 1. MOM 30 ml PO every 24 hrs. PRN if no BM in past 72 hrs. 2. Dulcolax suppository 10 mg rectally every 24 hrs. PRN if MOM was not effective. 3. Fleet enema 7 to 19 gm/118 ml insert rectally every 24 hrs. PRN if Dulcolax suppository was not effective. 4. Miralax 17 gm PO every 24 hrs. PRN for constipation if the resident has not had a BM in past 72 hrs. A review of Resident 1's MAR, dated ,d+[DATE], indicated the facility did not administer Resident 1 any PRN laxative medications as ordered between the dates of [DATE] to [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's General Acute Care Hospital (GACH) Emergency Department (ED) notes, dated [DATE] at 5:28 p.m., indicated the GACH admitted Resident 1 to the intensive care unit (ICU, a designated area of a hospital facility that is dedicated to the care of patients who are seriously ill) for a large bowel obstruction, septic shock (widespread infection causing organ failure and dangerously low blood pressure), and pneumonia (a lung infection). A review of Resident 1 Certificate of Death, dated [DATE] at 1:15 p.m., indicated Resident 1's cause of death was acute hypoxic respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide), sepsis, and pneumonia. During a telephone interview on [DATE] at 1:57 p.m., LVN 1 stated she was familiar and took of Resident 1 but could not recall giving any laxatives medication (medication to loosen stools and increase bowel movements) in the past. LVN 1 stated if during a stand-up meeting a resident was reported of no BM, she would give PRN and if no result, she would call the physician. During a telephone interview and concurrent record review of Resident 1's ,d+[DATE] Activity of Daily Living (ADL, the tasks of everyday life), and MAR, on [DATE] at 8:55 a.m., the DSD verified and stated Resident 1's had no BM on [DATE] to [DATE] and MAR did not indicate licensed nurse administered PRN laxatives. During a telephone interview and concurrent record review of Resident's 1 ADL records on [DATE] at 12 p.m. , the Director of Nursing (DON) stated Resident 1 listed PRN laxative medications were standing orders. The DON did not answer if physician was verified about the PRN laxatives orders. During another telephone interview and concurrent record review on [DATE] at 8:30 a.m., the DSD verified and stated Resident 1's ,d+[DATE] MAR did not indicate licensed nurse administered PRN laxatives. During a telephone interview on [DATE] at 9:20 a.m., LVN 2 stated the facility's process if a resident had no BM for three days, he would give the PRN laxative medication as ordered. LVN 2 stated if the medication was not effective, he would call the physician. LVN 2 stated he took care of Resident 1 in ,d+[DATE] but could not recall giving PRN laxative medication. During a telephone interview on [DATE] at 7:10 p.m., LVN 3 stated she would normally ask the CNA staff assigned to her residents if residents had a BM at the end of the shift and would document in her nurse's notes. LVN 3 stated if the resident had no BM for 2 to 3 days, she would give the PRN laxative medication, wait for 1 to 2 hours, and if the resident still had no BM, she would call the resident's physician. A review of facility's P & P titled Medication Errors, effective date [DATE] review date [DATE], indicated a medication error is defined as a discrepancy between what the physician/advanced practice provider (APP) ordered and what the resident/patient (hereinafter patient) received. Type of errors included: medication omission; wrong patient, dose, route, rate, or time; incorrect administration technique. The purpose was to provide the safe administration of medication.