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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Nursing and Rehabilitation Center	11900 Ramona Boulevard El Monte, CA 91732

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 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 45064 Based on interview and record review, the facility failed to implement its policies and procedures (P&P) titled, IV (an intravenous [within a vein] line is a soft, flexible tube placed inside a vein, usually in the hand or arm) Administration (send directly into the vein), and Central Venous (a thin, flexible tube that is inserted into a vein, usually below the right collarbone [a bone at the base of the front of the neck] and Midline Catheter (a catheter inserted in the upper arm with the tip located just below the axilla [armpit]) Care, and follow the manufacturer's instructions for care of the central venous catheter (CVC - an indwelling device inserted into a large, central vein to administer fluid, medication, and/or treatment) for one of one sampled resident (Resident 1) by failing to: 1. Ensure Registered Nurse Supervisor (RNS) 3 flushed (method of clearing intravenous [IV- into or within a vein] line) Resident 1's permanent catheter (Permacath- a type of CVC used for short-term or long-term hemodialysis [a treatment to filter wastes and water from the blood, as the kidneys did when the kidneys were healthy]) with saline (a solution of salt in water) after the completion of the IV infusion (a method of putting fluids into the bloodstream) and documented the procedure in Resident 1's clinical record (chart). 2. Ensure RNS 3 clamped (to hold or press tightly together with a securing device) and capped (covered or closed with a cap) Resident 1's Permacath when the Permacath was not in use. As a result, on 5/10/2024 at 12:45 AM, Resident 1 experienced massive (very large) bleeding from Resident 1's Permacath. Resident 1 was transferred and admitted to the General Acute Care Hospital (GACH) 1's Intensive Care Unit (ICU- unit in hospital providing intensive care for critically ill or injured residents/patients) on 5/10/2024 at 1:14 AM for further evaluation and treatment. Cross Reference F842 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility originally admitted Resident 1 on 4/25/2024, and readmitted Resident 1 on 5/7/2024, with diagnoses that included type 2 diabetes mellitus (a condition in which the body had trouble controlling blood sugar and using it for energy), anxiety disorder (involved persistent and excessive worry that interfered with daily activities), end stage renal disease (ESRD- a medical condition in which a person's kidney ceased functioning on a permanent basis), and dependence on renal (kidney) hemodialysis treatment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024

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F 0694 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's History and Physical (H&P) dated 4/28/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Physician Order (PO) dated 5/4/2024, the PO indicated, Resident 1 had an order for heparin sodium injection solution (medication used to thin the blood and prevent blood clots) 5000 unit per milliliter (unit/ml- unit of measurement), inject 5000 unit/ml subcutaneously (beneath the skin) every 12 hours for deep vein thrombosis (DVT- blood clot in a deep vein, usually in the legs) prophylaxis (prevention). During a review of Resident 1's PO dated 5/7/2024, the PO indicated, Resident 1 had an order to inspect Resident 1's dialysis site/Permacath to Resident 1's right upper chest for color, warmth, redness, edema (swelling), and/or bleeding every shift and to contact Resident 1's Primary Physician/Medical Doctor 1 (MD 1) if present. During a review of Resident 1's Untitled Care Plan (CP) dated 5/8/2024, the CP indicated, Resident 1 needed hemodialysis related to ESRD. The CP interventions included for staff to monitor, document, and report to MD 1 as needed for any signs and symptoms (s/sx) of infection to access site (Permacath) such as redness, swelling, warmth or drainage, and any s/sx of bleeding. During a review of Resident 1's Nurse's Dialysis Communication Record (NDCR) dated 5/9/2024, timed at 8:20 AM, the NDCR indicated, Resident 1 left the facility for Resident 1's dialysis treatment (on 5/9/2024) at 8:20 AM and returned to the facility (on 5/9/2024) at 12:30 PM. The NDCR indicated, Resident 1 had a CVC (Permacath) to Resident 1's right chest. The NDCR dated 5/9/2024 indicated there was no documentation the facility staff (assigned staff) assessed Resident 1's CVC site for redness, swelling, drainage, and/or bleeding as required on the NDCR. During a review of Resident 1's PO dated 5/9/2024, the PO indicated, Resident 1 had an order to administer Dextrose (a form of glucose [sugar]) IV solution 10 percent (%- unit of proportion) at 100 milliliters per hour (ml/hr- unit of measurement) due to hypoglycemia (low blood sugar) and Resident 1's inability to swallow. During a review of Resident 1's PO dated 5/9/2024, the PO indicated, Resident 1 had an order that staff may use Resident 1's Permacath for intravenous administration of medication. During a review of Resident 1's IV Medication Administration Record (IVMAR) dated 5/9/2024, the IVMAR indicated on 5/9/2024, at 3 PM, RNS 2 started to administer Dextrose IV solution 10% at 100 ml/hr intravenously for Resident 1. During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 5/10/2024, the MDS indicated Resident 1 had intact cognition (ability to think and process information). The MDS indicated Resident 1 required setup or clean-up assistance (helper assisted only prior to or following the activity) for eating and oral hygiene. The MDS indicated Resident 1 depended (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) on staff for toileting hygiene, showering/bathing, lower body dressing, rolling left and right, and toilet transfer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Paramedic (a person trained to give emergency medical care to people who were injured or ill) Report (PR) dated 5/10/2024, timed at 12:25 AM, the PR indicated, paramedics arrived at the facility on 5/10/2024 at 12:29 AM, and at Resident 1's bedside at 12:30 AM for complaint of Resident 1 bleeding. The PR indicated, the paramedics found Resident 1 in bed bleeding from Resident 1's dialysis port (extension tubing that made it easier to access the vein through the Permacath). The PR indicated, facility staff (Licensed Vocational Nurse [LVN] 3) had Resident 1's bleeding controlled with direct pressure and a towel. The PR indicated, facility staff (RNS 1) clamped (closed/fastened) Resident 1's (Permacath) port on Resident 1's right chest near the exit site of Resident 1's Permacath. The PR indicated, Resident 1's bleeding was controlled and Resident 1's vital signs (measurements of the body's most basic functions) were stabilized (to maintain at a given or unfluctuating level or quantity). The PR indicated, Resident 1 was transferred to GACH 1. During a review of Resident 1's Progress Notes (PN) dated 5/10/2024, the PN indicated, (on 5/10/2024) at 12:30 AM, LVN 3 noted massive bleeding from Resident 1's Permacath dialysis site possibly from ruptured (burst/leaked) catheter and missing locks (a device designed to bind or constrict or to press two or more parts together so as to hold them firmly). The PN indicated, staff (LVN 3) applied pressure and ice pack on the (catheter's) site. The PN indicated, Resident 1's oxygen saturation (O2 sat- a measure of how much oxygen is in the blood) was decreasing. The PN indicated, RNS 1 increased Resident 1's supplemental oxygen to 10 to 15 liters per minute (L/min- unit of flow rate) via non-rebreather mask (a device that gives oxygen, usually in an emergency). The PN indicated, staff (CNA 1) called 911 and the paramedics arrived after five to seven minutes and took Resident 1 to GACH 1 on 5/10/2024, at 12:45 AM. During a review of Resident 1's Change in Condition Evaluation (CICE) dated 5/10/2024, timed at 12:45 AM, the CICE indicated, on 5/10/2024, untimed, LVN 3 noticed that Resident 1 was acting slightly abnormal. The CICE indicated, Resident 1's room light was off, and LVN 3 noticed a dark colored spot near Resident 1's right side. The CICE indicated, LVN 3 turned on Resident 1's room light and saw a large amount of blood (location not indicated). The CICE indicated, LVN 3 called Certified Nursing Assistant (CNA) 1 and CNA 1 called 911 (a phone number used to contact the emergency services). The CICE indicated, LVN 3 applied pressure (location not indicated) to stop the bleeding. The CICE indicated, LVN 3 notified MD 1 on 5/10/2024 at 1:18 AM. During a review of Resident 1's GACH 1 Emergency Department Provider Note (EDPN) dated 5/10/2024, timed at 1:14 AM, the EDPN indicated, the ambulance brought in Resident 1 from the facility for bleeding from Resident 1's right chest wall dialysis catheter. The EDPN indicated, per the paramedics, Resident 1 was found in a pool of blood, blood-soaked sheets, with approximately 300 ml of blood on the floor. The EDPN indicated, per the paramedics, it was unclear how long or how Resident 1's Permacath opened. The EDPN indicated, upon Resident 1's arrival to GACH 1 ED, Resident 1 appeared pale, altered, anxious, and hypotensive (having low blood pressure [BP, the pressure of circulating blood against the walls of blood vessels]) with BP of 84/67 millimeters of mercury (mmHg) (Normal BP= 120/80 mm/hg). The EDPN indicated, while in GACH 1 ED, Resident 1 received one (1) unit of packed red blood cells (PRBC- blood transfusions used to improve blood oxygen [the amount of oxygen you have circulating in your blood] carrying capacity and restore blood volume). The EDPN indicated, Resident 1 would be admitted to GACH 1's ICU for further evaluation and treatment. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's GACH 1 Renal Consultation Note (RCN) dated 5/10/2024, timed at 7:29 PM, the RCN indicated, Resident 1 presented to GACH 1 with significant (serious/notable) bleeding from Resident 1's Permacath site. The RCN indicated, apparently the clamp (a device designed to constrict and press two or more parts together to hold them firmly) was opened, and the cap (cover) was not on the catheter. During an interview on 5/17/2024 at 7 AM with RNS 1, RNS 1 stated at approximately 12:30 AM on 5/10/2024, Licensed Vocational Nurse (LVN) 3 paged RNS 1 to come to Resident 1's room. RNS 1 stated when RNS 1 entered Resident 1's room, RNS 1 observed LVN 3's hands applying pressure on Resident 1's right upper chest where Resident 1's Permacath was located. RNS 1 inspected Resident 1's Permacath and noticed that blood was coming out from the two (2) extension tubing ports (a form of tubing used to add length to an existing infusion tubing) of Resident 1's Permacath. RNS 1 stated RNS 1 manually clamped the tubing above the 2 ports of Resident 1's Permacath and continued to apply pressure on Resident 1's right upper chest. RNS 1 stated RNS 1 observed the clamps and caps were missing from the 2 ports of Resident 1's Permacath. RNS 1 stated RNS 1 asked LVN 3 to get an ice pack and get a clamp from the dialysis kit (a kit with medical supplies and dialysis equipment) at Resident 1's bedside. RNS 1 stated RNS 1 clamped Resident 1's Permacath tubing above the 2 ports of the Permacath. RNS 1 stated the paramedics came within a few minutes and took Resident 1 to the hospital (GACH 1). RNS 1 stated RNS 1 did not see any caps or clamps on Resident 1's bed and RNS 1 did not know why the caps and clamps were missing from Resident 1's Permacath tubing. RNS 1 stated RNS 1 received training for care of Permacath/CVC in October of 2023. RNS 1 stated Resident 1's Permacath needed to be clamped and capped always when it (the Permcath) was not in use to prevent blood from flowing out of the ports. RNS 1 stated when Resident 1's Permacath was unclamped or uncapped, Resident 1 could be at risk for bleeding from the Permacath ports which could lead to complications such as blood loss and shock (a life-threatening condition that occurred when the body was not getting enough blood flow). During an interview on 5/17/2024 at 9:05 AM with RNS 2, RNS 2 stated on 5/9/2024 at around 2:30 PM, Resident 1 had low blood sugar. RNS 2 stated LVN 4 notified MD 1 and MD 1 ordered to give Dextrose 10 intravenous solution to Resident 1. RNS 2 stated RNS 2 was unable to insert a peripheral (away from the center) IV line on Resident 1. RNS 2 stated LVN 4 notified MD 1 of Resident 1's poor IV access and MD 1 ordered to use Resident 1's Permacath. RNS 2 stated RNS 2 started the Dextrose 10 IV infusion via Resident 1's Permacath (on 5/9/2024) at approximately 3 PM and endorsed (hand over or report) the IV infusion to RNS 3 (on 5/9/2024) at approximately 3:40 PM. During an interview on 5/17/2024 at 9:43 AM with RNS 3, RNS 3 stated RNS 3 received report from RNS 2 on 5/9/2024 (unable to recall time) that Resident 1 was receiving IV fluids via Resident 1's Permacath. RNS 3 stated the IV infusion was completed (on 5/9/2024) at 11:30 PM so RNS 3 disconnected the IV tubing from Resident 1's Permacath and flushed Resident 1's Permacath with 10 ml of saline. RNS 3 stated RNS 3 clamped Resident 1's Permacath extension tubing and capped the ports of Resident 1's Permacath. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/17/2024 at 11:25 AM with LVN 3, LVN 3 stated (on 5/10/2024) at approximately 12:25 AM, LVN 3 was at Resident 1's room door when LVN 3 saw Resident 1's hands on the headboard of Resident 1's bed. LVN 3 stated LVN 3 noticed a dark spot on the right side of Resident 1's gown while Resident 1's room light was off. LVN 3 stated LVN 3 immediately went inside Resident 1's room, turned on the light, and observed a big spot of blood on the right side of Resident 1's body. LVN 3 stated LVN 3 lifted Resident 1's blanket, bedsheet, and gown to see where the blood was coming from. LVN 3 stated Resident 1's Permacath dressing was covered with blood. LVN 3 stated LVN 3 observed drops of blood slowly dripping out from Resident 1's Permacath ports. LVN 3 stated LVN 3 did not see the caps at the end of Resident 1's Permacath extension tubings. LVN 3 stated LVN 3 immediately applied pressure on Resident 1's right chest and yelled out for help. LVN 3 stated CNA 1 came and LVN 3 instructed CNA 1 to call 911. LVN 3 stated RNS 1 came inside Resident 1's room and immediately requested for a bag of ice from another staff (LVN 2) to put on Resident 1's Permacath site. LVN 3 stated RNS 1 continued to apply pressure on Resident 1's Permacath site using RNS 1's hands. LVN 3 stated RNS 1 instructed LVN 3 to get a clamp from the dialysis kit. LVN 3 stated RNS 1 clamped the 2 tubes above the 2 ports of Resident 1's Permacath then the bleeding stopped. LVN 3 stated the paramedics came within a few minutes, assessed Resident 1, and told LVN 3 that Resident 1's Permacath was still intact (unbroken/undamaged). LVN 3 stated the paramedics took Resident 1 to GACH 1. During a follow-up interview on 5/17/2024 at 2:43 PM with RNS 3, RNS 3 stated (on 5/9/2024, unable to recall time) RNS 3 flushed Resident 1's Permacath with saline and clamped Resident 1's Permacath tubing after the IV infusion completed but did not document it. During an interview on 5/17/2024 at 4:07 PM with the Director of Nursing (DON), the DON stated licensed nurses (LVNs and RNs) must inspect and monitor the CVC/Permacath site for signs of redness, swelling, bleeding, pain, or any changes in condition. The DON stated it was important to clamp and cap the Resident 1's CVC/Permacath when it was not in use to prevent bleeding which could cause complications such as hypotension, blood loss, shock, or even death. During a review of Resident 1's GACH 1 Discharge Summary (DS) dated 5/18/2024, timed at 9:03 AM, the DS indicated, Resident 1 was admitted with hypotension (low blood pressure) and anemia (low red blood cells [a type of blood cell that delivered oxygen to the tissues in the body]). The DS indicated, Resident 1 had bleeding from Resident 1's Permacath and received blood transfusion and medication change while in GACH 1. During a review of the facility's P&P titled, IV Administration, revised in 1/2024, the P&P indicated, all central lines were capped or had an extension set applied. The P&P indicated; a closed system (a natural physical system that does not allow transfer of matter in or out of the system) was utilized on all continuous central vascular access lines. During a review of the facility P&P titled, Central Venous and Midline Catheter Care, revised in 1/2024, the P&P indicated, once the administration or infusion was complete, lock the catheter using saline. The P&P indicated, if the catheter was not in use, ensure it remained patent by locking it with saline every 24 hours. The P&P indicated, document date and time of procedure, individual's response to the procedure, signature, and credentials. The P&P indicated, if flushing a CVC, add amount of saline used. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Permacath Patient Information Packet (PPIP- manufacturer's instructions for care), undated, the PPIP indicated, extension clamps should only be open for aspiration (to draw in or out using a sucking motion), flushing, and dialysis treatment. The PPIP indicated, to prevent accidents, assure the security of all caps and bloodline connector prior to and between treatments. The PPIP indicated, never remove the cap at the end of the catheter. The PPIP indicated, cap and clamps of the catheter must be kept closed when not being used for dialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45064 Based on interview and record review, the facility failed to maintain a complete and accurate clinical record for one of one sampled residents (Resident 1) when Registered Nurse Supervisor (RNS) 3 did not document that RNS 3 flushed with saline (a solution of salt in water), clamped, and capped Resident 1's permanent catheter (Permacath- a type of central venous catheter [CVC- an indwelling device inserted into a large, central vein to administer fluid, medication, and/or treatment] used for short-term or long-term hemodialysis [a treatment to filter wastes and water from the blood, as the kidneys did when the kidneys were healthy]) after the completion of Resident 1's intravenous (IV, within a vein) infusion (a method of putting fluids into the bloodstream) on Resident 1's clinical record. This deficient practice had the potential to cause inconsistencies and errors in providing the necessary care and treatment to Resident 1. Cross Reference F694 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility originally admitted Resident 1 on 4/25/2024, and readmitted Resident 1 on 5/7/2024, with diagnoses that included type 2 diabetes mellitus (a condition in which the body had trouble controlling blood sugar and using it for energy), anxiety disorder (involved persistent and excessive worry that interfered with daily activities), end stage renal disease (ESRD- a medical condition in which a person's kidney ceased functioning on a permanent basis), and dependence on renal (kidney) hemodialysis treatment. During a review of Resident 1's History and Physical (H&P) dated 4/28/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's PO dated 5/9/2024, the PO indicated, Resident 1 had an order to administer Dextrose (a form of glucose [sugar]) IV solution 10 percent (%- unit of proportion) at 100 milliliters per hour (ml/hr- unit of measurement) due to hypoglycemia (low blood sugar) and Resident 1's inability to swallow. During a review of Resident 1's PO dated 5/9/2024, the PO indicated, Resident 1 had an order that staff may use Resident 1's Permacath for intravenous administration of medication. During a review of Resident 1's IV Medication Administration Record (IVMAR) dated 5/9/2024, the IVMAR indicated on 5/9/2024, at 3 PM, RNS 2 started to administer Dextrose IV solution 10% at 100 ml/hr intravenously for Resident 1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 5/10/2024, the MDS indicated Resident 1 had intact cognition (ability to think and process information). The MDS indicated Resident 1 required setup or clean-up assistance (helper assisted only prior to or following the activity) for eating and oral hygiene. The MDS indicated Resident 1 depended (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) on staff for toileting hygiene, showering/bathing, lower body dressing, rolling left and right, and toilet transfer. During a review of Resident 1's Paramedic (a person trained to give emergency medical care to people who were injured or ill) Report (PR) dated 5/10/2024, timed at 12:25 AM, the PR indicated, paramedics arrived at the facility on 5/10/2024 at 12:29 AM, and at Resident 1's bedside at 12:30 AM for complaint of Resident 1 bleeding. The PR indicated, the paramedics found Resident 1 in bed bleeding from Resident 1's dialysis port (extension tubing that made it easier to access the vein through the Permacath). The PR indicated, facility staff (Licensed Vocational Nurse [LVN] 3) had Resident 1's bleeding controlled with direct pressure and a towel. The PR indicated, facility staff (RNS 1) clamped (closed/fastened) Resident 1's (Permacath) port on Resident 1's right chest near the exit site of Resident 1's Permacath. The PR indicated, Resident 1's bleeding was controlled and Resident 1's vital signs (measurements of the body's most basic functions) were stabilized (to maintain at a given or unfluctuating level or quantity). The PR indicated, Resident 1 was transferred to GACH 1. During a review of Resident 1's Progress Notes (PN) dated 5/10/2024, the PN indicated, (on 5/10/2024) at 12:30 AM, LVN 3 noted massive bleeding from Resident 1's Permacath dialysis site possibly from ruptured (burst/leaked) catheter and missing locks (a device designed to bind or constrict or to press two or more parts together so as to hold them firmly). The PN indicated, staff (LVN 3) applied pressure and ice pack on the (catheter's) site. The PN indicated, Resident 1's oxygen saturation (O2 sat- a measure of how much oxygen is in the blood) was decreasing. The PN indicated, RNS 1 increased Resident 1's supplemental oxygen to 10 to 15 liters per minute (L/min- unit of flow rate) via non-rebreather mask (a device that gives oxygen, usually in an emergency). The PN indicated, staff (CNA 1) called 911 and the paramedics arrived after five to seven minutes and took Resident 1 to GACH 1 on 5/10/2024, at 12:45 AM. During a review of Resident 1's Change in Condition Evaluation (CICE) dated 5/10/2024, timed at 12:45 AM, the CICE indicated, on 5/10/2024, untimed, LVN 3 noticed that Resident 1 was acting slightly abnormal. The CICE indicated, Resident 1's room light was off, and LVN 3 noticed a dark colored spot near Resident 1's right side. The CICE indicated, LVN 3 turned on Resident 1's room light and saw a large amount of blood (location not indicated). The CICE indicated, LVN 3 called Certified Nursing Assistant (CNA) 1 and CNA 1 called 911 (a phone number used to contact the emergency services). The CICE indicated, LVN 3 applied pressure (location not indicated) to stop the bleeding. The CICE indicated, LVN 3 notified MD 1 on 5/10/2024 at 1:18 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's GACH 1 Emergency Department Provider Note (EDPN) dated 5/10/2024, timed at 1:14 AM, the EDPN indicated, the ambulance brought in Resident 1 from the facility for bleeding from Resident 1's right chest wall dialysis catheter. The EDPN indicated, per the paramedics, Resident 1 was found in a pool of blood, blood-soaked sheets, with approximately 300 ml of blood on the floor. The EDPN indicated, per the paramedics, it was unclear how long or how Resident 1's Permacath opened. The EDPN indicated, upon Resident 1's arrival to GACH 1 ED, Resident 1 appeared pale, altered, anxious, and hypotensive (having low blood pressure [BP, the pressure of circulating blood against the walls of blood vessels]) with BP of 84/67 millimeters of mercury (mmHg) (Normal BP= 120/80 mm/hg). The EDPN indicated, while in GACH 1 ED, Resident 1 received one (1) unit of packed red blood cells (PRBC- blood transfusions used to improve blood oxygen [the amount of oxygen you have circulating in your blood] carrying capacity and restore blood volume). The EDPN indicated, Resident 1 would be admitted to GACH 1's ICU for further evaluation and treatment. During a review of Resident 1's GACH 1 Renal Consultation Note (RCN) dated 5/10/2024, timed at 7:29 PM, the RCN indicated, Resident 1 presented to GACH 1 with significant (serious/notable) bleeding from Resident 1's Permacath site. The RCN indicated, apparently the clamp (a device designed to constrict and press two or more parts together to hold them firmly) was opened, and the cap (cover) was not on the catheter. During an interview on 5/17/2024 at 7 AM with RNS 1, RNS 1 stated at approximately 12:30 AM on 5/10/2024, Licensed Vocational Nurse (LVN) 3 paged RNS 1 to come to Resident 1's room. RNS 1 stated when RNS 1 entered Resident 1's room, RNS 1 observed LVN 3's hands applying pressure on Resident 1's right upper chest where Resident 1's Permacath was located. RNS 1 inspected Resident 1's Permacath and noticed that blood was coming out from the two (2) extension tubing ports (a form of tubing used to add length to an existing infusion tubing) of Resident 1's Permacath. RNS 1 stated RNS 1 manually clamped the tubing above the 2 ports of Resident 1's Permacath and continued to apply pressure on Resident 1's right upper chest. RNS 1 stated RNS 1 observed the clamps and caps were missing from the 2 ports of Resident 1's Permacath. RNS 1 stated RNS 1 asked LVN 3 to get an ice pack and get a clamp from the dialysis kit (a kit with medical supplies and dialysis equipment) at Resident 1's bedside. RNS 1 stated RNS 1 clamped Resident 1's Permacath tubing above the 2 ports of the Permacath. RNS 1 stated the paramedics came within a few minutes and took Resident 1 to the hospital (GACH 1). RNS 1 stated RNS 1 did not see any caps or clamps on Resident 1's bed and RNS 1 did not know why the caps and clamps were missing from Resident 1's Permacath tubing. RNS 1 stated RNS 1 received training for care of Permacath/CVC in October of 2023. RNS 1 stated Resident 1's Permacath needed to be clamped and capped always when it (the Permcath) was not in use to prevent blood from flowing out of the ports. RNS 1 stated when Resident 1's Permacath was unclamped or uncapped, Resident 1 could be at risk for bleeding from the Permacath ports which could lead to complications such as blood loss and shock (a life-threatening condition that occurred when the body was not getting enough blood flow). During an interview on 5/17/2024 at 9:05 AM with RNS 2, RNS 2 stated on 5/9/2024 at around 2:30 PM, Resident 1 had low blood sugar. RNS 2 stated LVN 4 notified MD 1 and MD 1 ordered to give Dextrose 10 intravenous solution to Resident 1. RNS 2 stated RNS 2 was unable to insert a peripheral (away from the center) IV line on Resident 1. RNS 2 stated LVN 4 notified MD 1 of Resident 1's poor IV access and MD 1 ordered to use Resident 1's Permacath. RNS 2 stated RNS 2 started the Dextrose 10 IV infusion via Resident 1's Permacath (on 5/9/2024) at approximately 3 PM and endorsed (hand over or report) the IV infusion to RNS 3 (on 5/9/2024) at approximately 3:40 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Nursing and Rehabilitation Center	11900 Ramona Boulevard El Monte, CA 91732

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/17/2024 at 9:43 AM with RNS 3, RNS 3 stated RNS 3 received report from RNS 2 on 5/9/2024 (unable to recall time) that Resident 1 was receiving IV fluids via Resident 1's Permacath. RNS 3 stated the IV infusion was completed (on 5/9/2024) at 11:30 PM so RNS 3 disconnected the IV tubing from Resident 1's Permacath and flushed Resident 1's Permacath with 10 ml of saline. RNS 3 stated RNS 3 clamped Resident 1's Permacath extension tubing and capped the ports of Resident 1's Permacath. During an interview on 5/17/2024 at 11:25 AM with LVN 3, LVN 3 stated (on 5/10/2024) at approximately 12:25 AM, LVN 3 was at Resident 1's room door when LVN 3 saw Resident 1's hands on the headboard of Resident 1's bed. LVN 3 stated LVN 3 noticed a dark spot on the right side of Resident 1's gown while Resident 1's room light was off. LVN 3 stated LVN 3 immediately went inside Resident 1's room, turned on the light, and observed a big spot of blood on the right side of Resident 1's body. LVN 3 stated LVN 3 lifted Resident 1's blanket, bedsheet, and gown to see where the blood was coming from. LVN 3 stated Resident 1's Permacath dressing was covered with blood. LVN 3 stated LVN 3 observed drops of blood slowly dripping out from Resident 1's Permacath ports. LVN 3 stated LVN 3 did not see the caps at the end of Resident 1's Permacath extension tubings. LVN 3 stated LVN 3 immediately applied pressure on Resident 1's right chest and yelled out for help. LVN 3 stated CNA 1 came and LVN 3 instructed CNA 1 to call 911. LVN 3 stated RNS 1 came inside Resident 1's room and immediately requested for a bag of ice from another staff (LVN 2) to put on Resident 1's Permacath site. LVN 3 stated RNS 1 continued to apply pressure on Resident 1's Permacath site using RNS 1's hands. LVN 3 stated RNS 1 instructed LVN 3 to get a clamp from the dialysis kit. LVN 3 stated RNS 1 clamped the 2 tubes above the 2 ports of Resident 1's Permacath then the bleeding stopped. LVN 3 stated the paramedics came within a few minutes, assessed Resident 1, and told LVN 3 that Resident 1's Permacath was still intact (unbroken/undamaged). LVN 3 stated the paramedics took Resident 1 to GACH 1. During a follow-up interview on 5/17/2024 at 2:43 PM with RNS 3, RNS 3 stated (on 5/9/2024, unable to recall time) RNS 3 flushed Resident 1's Permacath with saline and clamped Resident 1's Permacath tubing after the IV infusion completed but did not document it. During an interview on 5/17/2024 at 4:07 PM with the Director of Nursing (DON), the DON stated licensed nurses (LVNs and RNs) must inspect and monitor the CVC/Permacath site for signs of redness, swelling, bleeding, pain, or any changes in condition. The DON stated it was important to clamp and cap the Resident 1's CVC/Permacath when it was not in use to prevent bleeding which could cause complications such as hypotension, blood loss, shock, or even death. During a review of Resident 1's GACH 1 Discharge Summary (DS) dated 5/18/2024, timed at 9:03 AM, the DS indicated, Resident 1 was admitted with hypotension (low blood pressure) and anemia (low red blood cells [a type of blood cell that delivered oxygen to the tissues in the body]). The DS indicated, Resident 1 had bleeding from Resident 1's Permacath and received blood transfusion and medication change while in GACH 1. During a review of the facility P&P titled, Central Venous and Midline Catheter Care, revised in 1/2024, the P&P indicated, once the administration or infusion was complete, lock the catheter using saline. The P&P indicated, if the catheter was not in use, ensure it remained patent by locking it with saline every 24 hours. The P&P indicated, document date and time of procedure, individual's response to the procedure, signature, and credentials. The P&P indicated, if flushing a CVC, add amount of saline used.