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	10/09/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) with psychotropic medication (any drug that affects the brain activities associated with mental processes and behavior) order was free from unnecessary drugs, according to the facility's policy and procedure (P&P) titled, Psychotropic Medications, by failing to: Ensure Resident 1 was not ordered Seroquel (medication used to treat symptoms of psychosis [severe mental condition in which thought and emotions are so affected that contact is lost with external reality] and other mental health disorders) 25 milligrams (mg- unit of measurement) for false accusations towards staff for unspecified psychosis not due to a substance (drug) or known psychological condition on 8/23/2024 when Resident 1 was not diagnosed by Psychiatrist/Medical Doctor (MD) 2 with unspecified psychosis. This deficient practice had the potential to result in significant adverse consequences from the use of unnecessary medications. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm (cancerous tumor/a disease in which abnormal cells divide uncontrollably and destroy body tissue) of uterus, malignant neoplasm of right kidney, and unspecified psychosis. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/14/2024, the MDS indicated Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 1 had no evidence of an acute change in mental status. The MDS indicated Resident 1 did not present with inattention (difficult focusing or easy distractible), disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching form subject to subject), and/or altered level of consciousness (easily startled to any sound or touch, repeatedly dosing of when asked questions but responding to voice or touch, very difficult to arouse and keep aroused during interview, and/or could not be aroused). The MDS indicated Resident 1 did not have delusions (fixed belief that persists despite evidence of the contrary) or hallucinations (false perceptions of things that are not real, involving the senses of sight, sound, smell, taste, or touch). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	10/09/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change in Condition Evaluation (CICE) dated 8/21/2024 at 11:38 am, the CICE indicated Resident 1 was having behavioral symptoms. The CICE indicated Resident 1 was noted with increased confusion and reports of hallucinations. The CICE indicated Resident 1 had increased confusion manifested by forgetting Resident 1's room and forgetting current location. The CICE indicated Resident 1 had hallucinations reported by, seeing people in room. The CICE indicated Medical Doctor/Primary Care Provider (MD) 1 recommended Resident 1 be transferred to a general acute care hospital (GACH). During a review of Resident 1's physician order (PO) dated 8/21/2024, the PO indicated Resident 1 may have stat (immediately or promptly) psych (psychiatric) consultation for increased confusion and hallucinations. During a review of Resident 1's untitled care plan (CP) initiated 8/21/2024, the CP indicated Resident 1 had episodes of confusion and reports of hallucinations. The CP goal indicated Resident 1 would have no evidence of behavior problems (episodes of confusion and reports of hallucinations) by the review date of 11/10/2024. The CP interventions indicated for staff to administer medications as ordered and monitor for side effects and effectiveness, document behaviors and Resident 1's response to interventions, and to discuss behavior, and explain/reinforce why behavior was inappropriate and/or unacceptable. The CP indicated no specific hallucinations Resident 1 was experiencing. During a review of Resident 1's Psychiatry Evaluation (PE) dated 8/23/2024, the PE indicated Resident 1 was having paranoid delusions that people wanted to harm Resident 1. The PE indicated Resident 1's memory was intact. The PE indicated Resident 1 had a diagnosis of unspecified schizophrenia (serious mental illness in which people interpret reality abnormally) spectrum disorder, and generalized anxiety disorder (GAD- persistent feeling of dread or panic that can interfere with daily life). The PE indicated MD 2 recommended to start Resident 1 on Seroquel 25 mg, by mouth every night at bedtime. During a review of Resident 1's telephone orders (TO) dated 8/23/2024 at 5:57 pm, the TO indicated a physician order for Seroquel 25 mg, give one tablet by mouth at bedtime for false accusation towards staff related to unspecified psychosis not due to a substance or known psychological condition, and hold if Resident 1 was sedated. The TO was electronically signed by Primary Care Provider/MD 1 on 8/26/2024. During a review of Resident 1's TO dated 8/23/2024 at 5:59 pm, the TO indicated MD 1 obtained informed consent from Resident 1's responsible party for anti-psychotic use while on Seroquel. During a review of Resident 1's TO dated 8/23/2024 at 5:59 pm, the TO indicated a physician's order for staff to monitor for episodes of psychotic behavior as evidenced by false accusation towards staff while on Seroquel, every shift. An attempt to interview MD 2 was made on 9/24/2024 at 2:07 pm and 9/25/2024 at 11 am, however MD 2 was not able to be reached. (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	10/09/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/24/2024 at 4:18 pm with MD 1, MD 1 stated MD 1 did not have a medical work-up for Resident 1 in terms of mental illness, but that Resident 1 was showing signs of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). MD 1 stated if MD 2 was going to make a mental health disorder diagnosis such as schizophrenia or psychosis for Resident 1, it was important for the psychiatrist (MD 2) to consult with MD 1, a psychologist (medical provider who studies cognitive, emotional, and social processes and behaviors in residents by observing, interpreting, and recording how people relate to one another and to their environments), neurologist (medical doctor who specializes in diagnosing, treating, and managing conditions that affect the brain, spinal cord, and nerves), and other medical specialties before making a diagnosis of schizophrenia or psychosis in an elderly resident. MD 1 stated ordering Seroquel for Resident 1 was a huge risk because an accusation or allegation could not be deemed false until an investigation was completed. MD 1 stated it was possible medical causes such as pain or infection needed to be ruled out that made Resident 1 make accusations. MD 1 stated the order for Seroquel for Resident 1 for making false accusations was not an appropriate medication order because Seroquel was not intended to treat false accusations, but to treat specific behaviors from known psychiatric diagnoses such as agitation or aggression. MD 1 stated in psychotropic medication orders, the specific behaviors needed to be listed for staff to monitor the behaviors and patient safety to ensure effectiveness of the medication. MD 1 stated it was possible that if a psychotropic medication such as Seroquel was given to Resident 1, Resident 1 could become over-sedated and potential abuse could happen to Resident 1 because staff would assume anything Resident 1 said was a false accusation. During an interview on 9/24/2024 at 5:45 pm with the Director of Nursing (DON), the DON stated when psychotropic medications were ordered, the order must include the diagnosis and the behaviors it was targeting to monitor for the effectiveness of the medication. The DON stated Resident 1's Seroquel order for false accusations toward staff was not appropriate because the order was not targeting an appropriate behavior. The DON stated it was important to justify the appropriate medications with an appropriate diagnosis and behaviors. The DON stated appropriate behaviors for Seroquel use were increased agitation or verbal aggression. The DON stated Resident 1 could have been sedated against her will. The DON stated it was possible Resident 1 could be afraid to speak up if something was happening to Resident 1 and could be potentially dangerous. During a review of the facility's P&P titled, Psychotropic Medications, revised 12/2023, the P&P indicated, It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented the in the clinical record. The P&P indicated, Psychotropic medications shall not be administered for the purpose of discipline or convenience. The P&P indicated, They (psychotropic medications) are to be administered only when required to treat the resident's medical symptoms and will be considered only after non-pharmacological interventions had been attempted and failed.