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	02/05/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46687 Based on interview and record review, the facility failed to promptly (quickly/with little or no delay) notify the physician for one of eight sampled residents (Resident 8) who experienced a change of condition (COC- a sudden clinically important deviation from a resident/patient's baseline in physical, behavioral, or functional domains) as indicated in the facility's policy and procedure (P&P) titled, Significant Change of Condition, Response, by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 3 promptly notified Resident 8's Primary Care Provider/Medical Doctor (MD) 2 when LVN 3 observed an increase in swelling in Resident 8's left leg and foot on 1/15/2025. 2. Ensure LVN 3 promptly notified MD 2 on 1/20/2025 when Resident 2's left leg and foot condition did not improve. These deficient practices resulted in a delay in providing the care and treatment for Resident 1 and placed Resident 1 at risk for further skin breakdown. Cross Reference F684 Findings: During a review of Resident 8's Admission Record (AR), the AR indicated the facility initially admitted Resident 8 on 6/15/2025, and readmitted Resident 8 on 5/4/2024, with diagnoses that included type 2 diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel) with diabetic neuropathy (condition that involves damage to the peripheral nervous system from injury or disease process) and chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should). (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 02/05/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool) dated 11/5/2024, the MDS indicated Resident 8 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs but provides less than half the effort) with showering/bathing self and putting on/taking off footwear. The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with lying to sitting on side of bed, chair/bed-to-chair transfers, and walking 10 feet. The MDS indicated Resident 8 used a wheelchair. The MDS indicated Resident 8 had one venous ulcer (an open sore on the leg caused by poor blood circulation in the veins) and arterial ulcer (an ulcer due to inadequate blood supply to the affected area) present. During a review of Resident 8's untitled care plan (CP) initiated on 12/18/2025, and revised on 1/30/2025, the CP indicated Resident 8 had left lower leg scattered venous ulcer. The CP interventions included for staff to administer treatment as ordered, monitor/document/report to MD as needed for signs and symptoms (s/sx) of infection: green drainage, foul odor, redness, and swelling, and document progress in wound healing on an ongoing basis and notify MD 2 as indicated. During a review of Resident 8's untitled CP initiated on 1/14/2025, the CP indicated Resident 8 had left leg/actual impairment to skin integrity related to scattered skin irritation. The CP interventions included to monitor/document location, size, and treatment of skin injury and report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. During a concurrent observation and interview on 2/5/2025 at 12:55 pm with LVN 3, Resident 8's left toes were observed. LVN 3 stated LVN 3 had been monitoring Resident 8's edema to the feet since 12/2024. LVN 3 stated Resident 8's left second, and third toes were black and purple. LVN 3 stated the left great toe was swollen with purple discoloration on the inner side that was partially opened. LVN 3 stated Resident 8's left foot had plus 4 pitting edema (severe swelling that leaves a deep indentation in the skin that takes more than 30 seconds to go away). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/2025 at 1:10 pm with LVN 3, Resident 3's COC form dated 1/17/2025 and Progress Notes (PN) dated 1/2025 were reviewed. LVN 3 stated on 1/15/2025, LVN 3 observed an increase in swelling to Resident 8's left foot. LVN 3 stated swelling was an indication of a circulation problem that could lead to complications like ulcers and wounds to the legs, feet, and toes. LVN 3 stated LVN 3 was supposed to complete a COC form and notify Resident 8's physician (MD 2) because it was change in Resident 8's baseline. LVN 3 stated Resident 8 was on monitoring for left foot swelling but LVN 3 was only visually monitoring the swelling. LVN 3 stated on 1/16/2025, the swelling was the same. LVN 3 stated LVN 3 did not complete a COC form or notify MD 2. LVN 3 stated on 1/17/2025, LVN 3 observed the same swelling and observed Resident 8's left second, and third toes had open wounds. LVN 3 stated if Resident 8's physician had been notified and a COC form had been created then it was possible Resident 8's toe wounds may not have ruptured and opened because LVN 3 could have gotten a physician order to monitor and treat the swelling, with all staff monitoring. LVN 3 stated (in general) when a COC form was created, licensed nurses were supposed to monitor a resident's condition for 72 hours to observe for any changes. LVN 3 stated the protocol was to follow up with the physician within 72 hours of a resident's COC if the condition had not improved or had gotten worse. LVN 3 stated on 1/20/2025, the toe wounds had not improved and had gotten worse. LVN 3 stated it was important to reevaluate a COC after 72 hours to ensure the condition was being treated appropriately. LVN 3 stated not notifying Resident 8's physician in a timely manner put Resident 8 at risk for developing further skin breakdown/issues. LVN 3 stated Resident 8's toe wounds could get worse in a matter of days and cause irreversible damage when the wounds were not treated in a timely manner. LVN 3 stated Resident 8's physician should have been notified on 1/20/2025 when the toes were not improving. During an interview on 2/5/2025 at 5:05 pm with the Director of Nursing (DON), the DON stated a COC was any new finding beyond a resident's baseline. The DON stated (in general) when a resident had a COC, the licensed nurses were supposed to notify the physician, call the resident's family (if needed), update the care plan, inform other licensed nurses about the condition, and update the certified nurse assistants. The DON stated licensed nurses were supposed to carry out any new orders and monitor the condition for 72 hours. The DON stated if after 72 hours the condition stayed the same or became worse, the physician was supposed to be notified and the licensed nurses needed to complete another COC if the condition worsened. The DON stated licensed nurses were supposed to notify the physician after 72 hours if the treatment was not working and if any new orders, treatment, tests or further evaluation was needed. The DON stated edema or swelling in the legs was considered a COC if it was newly developed or got worse from baseline. The DON stated the physician needed to evaluate the resident to ensure nothing else cardiovascularly (relating to the heart and blood vessels) was going with the resident. The DON stated edema/swelling was a sign of circulation issues that could lead to wounds in the feet or toes. The DON stated had Resident 8's physician been informed on 1/15/2025 that Resident 8 had an increase in swelling to the left feet and legs, it was possible Resident 8's toe wounds may not have developed and/or opened. The DON stated on 1/20/2025 when Resident 8's toe wounds were getting worse, a new COC form should have completed due to the severity of Resident 8's vascular problems and toes wounds. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Significant Change of Condition, Response, revised 2/2025, the P&P indicated, .facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with interdisciplinary comprehensive assessment and plan of care. The P&P indicated, If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to) . Change in ability or decline in physical function . Any signs or symptoms of infections . New complaints of pain or worsening pain . The P&P indicated, The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. The P&P indicated, The resident will then be placed on the 24 Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions.

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 02/05/2025
NAME OF PROVIDER OR SUPPLIER Ramona Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11900 Ramona Boulevard El Monte, CA 91732	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46687 Based on interview and record review, the facility failed to monitor and document a change of condition for one of eight sampled residents (Resident 8) as indicated in the facility's policy and procedure (P&P) titled, Significant Change of Condition, Response, by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 3 completed a Situation-Background-Assessment-Recommendation (SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations)/Change of Condition (COC) form when LVN 3 observed an increase in swelling in Resident 8's left leg and foot on 1/15/2025. 2. Ensure LVN 3 completed an SBAR/COC form on 1/20/2025 when Resident 2's left leg and foot condition did not improve after 72 hours. These deficient practices resulted in a delay in providing the care and treatment for Resident 1 and placed Resident 1 at risk for further skin breakdown. Cross Reference F580 Findings: During a review of Resident 8's Admission Record (AR), the AR indicated the facility initially admitted Resident 8 on 6/15/2025, and readmitted Resident 8 on 5/4/2024, with diagnoses that included type 2 diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel) with diabetic neuropathy (condition that involves damage to the peripheral nervous system from injury or disease process) and chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should). During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool) dated 11/5/2024, the MDS indicated Resident 8 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs but provides less than half the effort) with showering/bathing self and putting on/taking off footwear. The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity and may be provided throughout the activity or intermittently) with lying to sitting on side of bed, chair/bed-to-chair transfers, and walking 10 feet. The MDS indicated Resident 8 used a wheelchair. The MDS indicated Resident 8 had one venous ulcer (an open sore on the leg caused by poor blood circulation in the veins) and arterial ulcer (an ulcer due to inadequate blood supply to the affected area) present. During a review of Resident 8's untitled care plan (CP) initiated on 12/18/2025, and revised on 1/30/2025, the CP indicated Resident 8 had left lower leg scattered venous ulcer. The CP interventions included for staff to administer treatment as ordered, monitor/document/report to MD as needed for signs and symptoms (s/sx) of infection: green drainage, foul odor, redness, and swelling, and document progress in wound healing on an ongoing basis and notify MD 2 as indicated. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's untitled CP initiated on 1/14/2025, the CP indicated Resident 8 had left leg/actual impairment to skin integrity related to scattered skin irritation. The CP interventions included to monitor/document location, size, and treatment of skin injury and report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. During a concurrent observation and interview on 2/5/2025 at 12:55 pm with LVN 3, Resident 8's left toes were observed. LVN 3 stated LVN 3 had been monitoring Resident 8's edema to the feet since 12/2024. LVN 3 stated Resident 8's left second, and third toes were black and purple. LVN 3 stated the left great toe was swollen with purple discoloration on the inner side that was partially opened. LVN 3 stated Resident 8's left foot had plus 4 pitting edema (severe swelling that leaves a deep indentation in the skin that takes more than 30 seconds to go away). During a concurrent interview and record review on 2/5/2025 at 1:10 pm with LVN 3, Resident 3's COC form dated 1/17/2025 and Progress Notes (PN) dated 1/2025 were reviewed. LVN 3 stated on 1/15/2025, LVN 3 observed an increase in swelling to Resident 8's left foot. LVN 3 stated swelling was an indication of a circulation problem that could lead to complications like ulcers and wounds to the legs, feet, and toes. LVN 3 stated LVN 3 was supposed to complete a COC form and notify Resident 8's physician (MD 2) because it was change in Resident 8's baseline. LVN 3 stated Resident 8 was on monitoring for left foot swelling but LVN 3 was only visually monitoring the swelling. LVN 3 stated on 1/16/2025, the swelling was the same. LVN 3 stated LVN 3 did not complete a COC form or notify MD 2. LVN 3 stated on 1/17/2025, LVN 3 observed the same swelling and observed Resident 8's left second, and third toes had open wounds. LVN 3 stated if Resident 8's physician had been notified and a COC form had been created then it was possible Resident 8's toe wounds may not have ruptured and opened because LVN 3 could have gotten a physician order to monitor and treat the swelling, with all staff monitoring. LVN 3 stated (in general) when a COC form was created, licensed nurses were supposed to monitor a resident's condition for 72 hours to observe for any changes. LVN 3 stated the protocol was to follow up with the physician within 72 hours of a resident's COC if the condition had not improved or had gotten worse. LVN 3 stated on 1/20/2025, the toe wounds had not improved and had gotten worse. LVN 3 stated it was important to reevaluate a COC after 72 hours to ensure the condition was being treated appropriately. LVN 3 stated not notifying Resident 8's physician in a timely manner put Resident 8 at risk for developing further skin breakdown/issues. LVN 3 stated Resident 8's toe wounds could get worse in a matter of days and cause irreversible damage when the wounds were not treated in a timely manner. LVN 3 stated Resident 8's physician should have been notified on 1/20/2025 when the toes were not improving. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 2/5/2025 at 5:05 pm with the Director of Nursing (DON), the DON stated a COC was any new finding beyond a resident's baseline. The DON stated (in general) when a resident had a COC, the licensed nurses were supposed to notify the physician, call the resident's family (if needed), update the care plan, inform other licensed nurses about the condition, and update the certified nurse assistants. The DON stated licensed nurses were supposed to carry out any new orders and monitor the condition for 72 hours. The DON stated if after 72 hours the condition stayed the same or became worse, the physician was supposed to be notified and the licensed nurses needed to complete another COC if the condition worsened. The DON stated licensed nurses were supposed to notify the physician after 72 hours if the treatment was not working and if any new orders, treatment, tests or further evaluation was needed. The DON stated edema or swelling in the legs was considered a COC if it was newly developed or got worse from baseline. The DON stated the physician needed to evaluate the resident to ensure nothing else cardiovascularly (relating to the heart and blood vessels) was going with the resident. The DON stated edema/swelling was a sign of circulation issues that could lead to wounds in the feet or toes. The DON stated had Resident 8's physician been informed on 1/15/2025 that Resident 8 had an increase in swelling to the left feet and legs, it was possible Resident 8's toe wounds may not have developed and/or opened. The DON stated on 1/20/2025 when Resident 8's toe wounds were getting worse, a new COC form should have completed due to the severity of Resident 8's vascular problems and toes wounds.

During a review of the facility's P&P titled, Significant Change of Condition, Response, revised 2/2025, the P&P indicated, .facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with interdisciplinary comprehensive assessment and plan of care. The P&P indicated, If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to) . Change in ability or decline in physical function . Any signs or symptoms of infections . New complaints of pain or worsening pain . The P&P indicated, The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. The P&P indicated, The resident will then be placed on the24 Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions.