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	04/07/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198 Based on interview and record review, the facility failed to follow the facility ' s policy and procedure (P&P) titled, Significant Change of Condition, Response, for one of three sampled residents (Resident 1) by failing to: 1. Ensure Certified Nursing Assistant (CNA) 1, reported to a charge nurse or supervisor an incident involving Resident 1 ' s left leg that got caught on the shower chair during 7 am - 3 pm shift. 2. Ensure Resident 1 ' s left leg was assessed by a charge nurse or supervisor during 7 am - 3 pm shift. These deficient practices had the potential to delay the necessary care and services for Resident 1. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 10/27/2023 and recently admitted on [DATE] with diagnoses that included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (one-sided weakness or inability to move) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side (left side of the body), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), muscle wasting (thinning of muscle tissue) and atrophy (decrease in size or wasting away of a body part). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/20/2025, the MDS indicated Resident 1 was usually understood by others and had the ability to usually understand others. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent (helper does all of the effort) with putting on/taking off footwear. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan Report (CP) for ADL (Activities of Daily Living) Self Care Performance, dated 7/31/2024, the CP indicated the goal for Resident 1 was to safely perform bed mobility, transfers, dressing, grooming, toilet use, and personal hygiene. The CP indicated Resident 1 required skin inspection to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The CP indicated Resident 1 required total assistance with transfers from chair to bed, bed to chair, and to the toilet. During a review of Resident 1 ' s Progress Notes (PN), dated 3/15/2025 and timed at 9:21 am, the PN indicated Registered Nurse (RN) 1 administered one tablet of Tylenol Extra Strength 500 milligrams (mg) to Resident 1 due to complaints of pain to the left foot. The PN indicated on 3/15/2025 at 10:05 am, RN 1 documented the Tylenol administered to Resident 1 was effective. The PN indicated nothing else was documented about Resident 1 ' s left foot. During a review of Resident 1 ' s eINTERACT Change in Condition Evaluation (CIC), dated 3/15/2025 at 5 pm, the CIC indicated Resident 1 complained of pelvic (bony structure inside the hips, buttocks, and pubic region) pain, left knee pain, and bruising on the left lateral (away from the middle of the body) leg. The CIC indicated Resident 1 was having throbbing pain on the left knee and pelvis. The CIC indicated the physician was notified on 3/15/2025 at 5 pm. The CIC indicated the physician recommended an x-ray (a photographic or digital image of the internal composition of a part of the body) of Resident 1 ' s pelvis, left tibia (shin bone), left fibula (calf bone), and left knee. During a review of Resident 1's General Acute Care Hospital (GACH) 1 records titled, Emergency Department Addendum Note (EDAN), The EDAN indicated Resident 1 sustained a depressed lateral tibial plateau fracture (a fracture where the top part of the tibia [shinbone], specifically the lateral [outer] plateau, is broken and the broken bone fragments are depressed or sunken into the bone. The EDAN indicated the fracture was most likely acute. During an interview on 3/19/2025 at 12:22 pm, with CNA 2, CNA 2 stated CNA 1 was giving Resident 1 a shower on 3/15/2025 during 7 am - 3 pm shift. CNA 2 stated when CNA 1 brought Resident 1 back to the room, CNA 2 heard Resident 1 complaining about the left foot being in pain. CNA 2 stated CNA 2 went to Resident 1 ' s room to see if CNA 1 needed assistance. CNA 1 informed CNA 2 that during transfer, Resident 1 ' s left leg got dragged. CNA 2 stated after CNA 2 assisted CNA 1 with putting socks on Resident 1 and brushing Resident 1 ' s hair, CNA 2 wheeled Resident 1 to the activity room. CNA 2 stated CNA 2 saw RN 1 and informed RN 1 that Resident 1 was having pain on the left foot due to the left foot [being] dragged. During an interview on 3/19/2025 at 2:01 pm, with CNA 1, CNA 1 stated CNA 1 transferred Resident 1 from the shower chair to the bed. CNA 1 stated one side of Resident 1 was paralyzed and Resident 1 ' s left leg got caught on one of the bars at the bottom of the shower chair. CNA 1 stated CNA 1 did not report the incident to a charge nurse or supervisor because Resident 1 did not complain of pain. During an interview on 3/19/2025 at 3:14 pm, with the Assistant Director of Nursing (ADON), the ADON stated if a resident was having new pain, there should have been a change of condition (COC) documented. The ADON stated the COC should have been reported to the physician and to the responsible party to intervene right away and prevent further complications. (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 4/7/2025 at 1:55 pm, with the Director of Nursing (DON), the DON stated CNA 1 should have reported the incident to a charge nurse or supervisor because if there was any change with a resident, the charge nurse would have to monitor. The DON stated if Resident 1 did not usually complain of pain and it was a new pain, it was considered a significant COC and RN 1 should have initiated the COC. The DON stated RN 1 should have assessed Resident 1 and notified the physician and responsible party. During a review of the facility ' s P&P titled, Significant Change of Condition, Response, revised in December 2024, the P&P indicated it is the policy of this 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 the interdisciplinary comprehensive assessment and plan of care. 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, fall or other related incident. 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 resident will then be placed on the 24-hour report and nursing will provide no less than three days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs, needed assist and resident behavior / acceptance of increased need or assistance will be monitored.