

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Ramona Rehabilitation and Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 485 W. Johnston Avenue Hemet, CA 92543	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038</p> <p>Based on interview and record review, the facility failed to ensure, for one of three sampled residents (Resident A), the staff removed the Certified Nursing Assistant (CNA 2) after the resident made an allegation of sexual abuse against the CNA.</p> <p>This failure resulted in Resident A seeing CNA 2, causing the resident to become upset and angry.</p> <p>Findings:</p> <p>On May 7, 2024, at 10:20 a.m., an unannounced visit to the facility was conducted to investigate an allegation of sexual abuse.</p> <p>During an interview on May 7, 2024, at 1:40 p.m., with CNA 1, CNA 1 stated on May 5, 2024, around lunch time, at 12:30 p.m., she was in the dining room preparing residents for lunch. CNA 1 stated she heard Resident A yelling at CNA 2 to go away, and get him away. CNA 1 stated she intervened and removed CNA 2 from the dining room. CNA 1 stated she asked Resident A, why she was upset. CNA 1 stated the resident reported that CNA 2 licked her and looked down at her private area. CNA 1 stated CNA 2 returned to the dining room to assist another resident who was seated in front of Resident A. CNA 1 stated while she was assisting Resident A during lunch, the resident stared at CNA 2 and refused to eat. CNA 1 stated she reported the incident to the RN Supervisor, an hour and a half later. CNA 1 stated, CNA 2 continued working after the allegation of abuse because he had to cover the RNA who went home early.</p> <p>A review of Resident A's admission record indicated, Resident A was admitted to the facility on [DATE], with diagnoses which included depression (feeling of sadness).</p> <p>A review of Resident A's Minimum Data Set (an assessment tool) dated March 29, 2024, indicated a Brief Interview for Mental Status (a tool used to screen and identify the cognitive condition of resident) score of 3 (cognitively impaired).</p> <p>A review of Resident A's Progress Notes, titled IDT (Interdisciplinary Team) Note, dated May 26, 2024, indicated, .regarding resident's allegation of inappropriate touching by a male staff member .</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on May 7, 2024, at 2:40 p.m., with the Registered Nurse Supervisor (RNS), the RNS stated CNA 1 informed her about Resident A's allegation against CNA 2 at around 2:15 p.m., on May 5, 2024. The RNS stated the staff should report an allegation of abuse to the administrator immediately. The RNS stated she removed CNA on the floor after the CNA reported to her, which was two hours after the allegation was made.</p> <p>During an interview on May 8, 2024, at 10:35 a.m., with CNA 1, CNA 1 stated she should have reported the allegation immediately after she was informed. CNA 1 further stated she should have separated CNA 2 from Resident A immediately after the allegation of abuse to protect Resident A.</p> <p>During an interview on May 8, 2024, at 3:12 p.m., with the Director of Nursing (DON), the DON stated the staff should have reported the incident between Resident A and CNA 2 to her within 2 hours. The DON stated, the staff should have separated CNA 2 from Resident A immediately for safety reasons.</p> <p>During a review of the facility's policy and procedure titled, RESIDENT ABUSE PREVENTING, REPORTING AND INVESTIGATING, dated October 2022, indicated .PROTECTION .If an incident is reported, discovered or suspected, where the health, welfare or safety of the residents is involved, the facility will take the following steps to prevent further potential abuse .If the suspected perpetrator is an employee: Remove employee immediately from the care of the resident .Suspend the employee during the investigation .</p>