

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/28/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to evaluate and develop new interventions for one of three sampled residents (Resident 1), who has poor decision making, high risk for fall, and had fall incidents on June 16 and June 22, 2025. This failure placed Resident 1 at risk for further falls which could result in serious injury while at the facility. On July 10, 2025, at 9:05 a.m., an unannounced visit was conducted at the facility to investigate a complaint on quality-of-care issues. On July 10, 2025, Resident 1's record was reviewed. Resident 1's admission Record, indicated Resident 1 was admitted on [DATE], with diagnoses which included prosthetic aortic valve replacement (surgery to restore proper blood flow through the heart), acute kidney disease (a condition the kidneys cannot filter waste from the blood) and dementia (impaired thinking abilities, forgetfulness).A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated June 13, 2025, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 13 (cognition intact).A review of Resident 1's Progress Notes, indicated the following:- June 13, 2025, at 4:10 p. m., indicated, .Pt (patient) showing S/S (signs and symptoms) of increased confusion .Pt stating that 'The air conditioner man is coming to pick me up.' 'I need to go to the front of the building so the truck can take me to buy things.:-June 14, 2025, at 10:01 p.m., indicated, .CNA (Certified Nursing Assistant) Entered room and found patient kneeling . Patient stated she was Trying to turn off her call light .:-June 15, 2025, at 10:16 p.m., indicated, .Resident Continues with increase Confusion and stating I'm being Held hostage and nobody wants to release me .-June 17, 2025, at 2:17 p.m., indicated, .Alert and responsive .Able to let needs known with confusion and forgetfulness .-June 22, 2025, at 10:24 a.m., indicated, .pt found sitting next to bed with back against bed, states she was coming from the restroom to go back to bed, resident states she was attempting to sit down on the bed when she slid down onto the floor, wheels locked, footwear on . neurochecks initiated .:-June 23, 2025, at 12:57 p.m., indicated, Fall IDT Meeting .Pt found sitting next to bed with back against bed .no bruising, redness, or swelling noted .IDT recommends to continue current intervention .:During further review of the IDT notes, the recommendations on June 23, 2025, were the same recommendations on June 16, 2025. There were no additional interventions recommended by the IDT after the second fall on June 22, 2025.-June 23, 2025, at 11:21 p.m., indicated, .Black eye to bilateral eye and discoloration to fore head .Resident had an unwitnessed fall on 06/22/25 (June 22, 2025) and was noted with [NAME] (sic) eye to bilateral eye and discoloration to forehead .date and time of MD (physician) notification: 06/24/2025 (June 24, 2025) 10:52 PM (p.m.) .Per MD to Observe and if Symptoms changes to send patient to ER .:-June 24, 2025, at 7:52 a.m., indicated, .pt do tried to get up x 3 (times three) on shift, pt always re direct to get some rest .:-June 26, 2025, at 2:26 a.m., indicated, .Resident alert with confusion. Resident noted to be taking brief and non-skid socks off and attempting self-transfer to BR (bathroom) .:-June 26, 2025, at 2:52 p.m., indicated, .Resident Had (sic) an unwitness (sic) Fall .If this has occurred before: Yes, resident had a fall on 6/14/25 & 6/22/25 . Resident found on floor on buttocks.resident no complaint of pain. MD notified 8:02 a.m no new orders.:-June 27, 2025, at 2:01 a.m., indicated, .increased confusion and bruising eyes and forehead. Physician notified and sent resident to ER via 911 ambulance. (family member) was notified on June 27, 2025, at 2 a.m .On July 10, 2025, at 10:30 a.m., an interview with Licensed Vocational Nurse (LVN)/charge nurse was conducted; and stated the following: a. The resident was found in the room at the side of the bed leaning against the bed with legs on to the side. b. The resident was alert and responded appropriately and stated she had not hit her head.c. There was no redness or bruise that she noticed during her shift. d. The resident explained she was trying to go to the rest room and did not use the call bell.e. She reported the resident's fall to the supervisor and did not recall a registered nurse assessing the resident after the fall.On July 10, 2025, at 10:40 a.m., during an interview with CNA 1, CNA 1 stated a resident is on close monitoring if considered high risk for fall. CNA 1 stated the staff would have to conduct rounds on the residents every 10-15 minutes to make sure the residents are safe, would offer drinks, and aid the bathroom.On July 11, 2025, at 11:02 a.m., during an interview, the Director of Nursing (DON) stated the process in managing falls follows the facility policy and procedure. The DON stated when a resident falls, the Administrator or the DON would be notified. She stated the IDT team would meet and review the incident usually a day after the fall. The IDT would look at the contributing factors resulting in a fall, which could be staffing issues, poor lighting, medications and diagnoses of the residents. The DON stated Resident 1's fall incident on . June 14 2025, was related to the resident's dementia and the resident underestimated her		