

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055873	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8665 LA Mesa Blvd. LA Mesa, CA 91942	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on interview and record review, the facility failed to follow the physician plan of care related to weekly weights and notification of the physician when the vital signs (blood pressure, heart rate, respiratory rate, and temperature) were outside of the parameters set (a measurable limit), for one of three residents (Resident 1), reviewed for care plans.</p> <p>This failure had the potential for the physician to be uninformed of changes, which could have negative consequences on Resident 1's overall health.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE], with diagnoses which included down syndrome (a genetic condition which affects the brain and normal development) and severe constipation (hard, dry stool, that is difficult to pass), per the facility's Admission Record.</p> <p>A review of Resident 1's clinical record was reviewed on 12/18/24:</p> <p>According to the Admission Minimum Data Set (MDS-a clinical assessment tool), dated 11/11/24, the cognitive assessment score was 00, indicating cognition was severely impaired. The Functional Abilities assessment indicated Resident 1 required maximum assistance with rolling from side to side, transferring, eating, grooming, and sitting. According to the Bladder and Bowel assessment, a urinary catheter (an indwelling rubber, flexible plastic tube that drains urine into an external collection bag), was present, and Resident 1 had bowel in continence.</p> <p>According to the physician's order, dated 11/4/24, Resident 1 was to have weekly weights.</p> <p>According to the facility's Weights and Vitals Summary, Resident 1 had weekly weights performed on 11/4/24 and 11/9/24, by a mechanical lift, (a device that assist staff with moving a resident from one place to another). No additional weights were performed between 11/9/24, until Resident 1's discharge on 11/22/24.</p> <p>According to the physician's order, dated 11/4/24, Notify Medical Doctor if the patient has ANY of the following symptoms: Temperature less than 96.8 or greater than 99.0 (normal 98.6). Heart rate greater then 90, respiratory rate greater then 20, systolic (the top number) blood pressure less than 100. Record every shift.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Medication Administration Record (MAR) was conducted. Vital signs recorded from 11/4/24 through 11/22/24 indicated the heart rate was greater the 90 beats per minute, eight times out of 51 opportunities. The systolic blood pressure was below 100, seven times out of 51 opportunities.</p> <p>The nursing progress notes were reviewed for the dates when Resident 1's heart rate was above 90 and the systolic blood pressure was below 100. There was no documented evidence the physician was notified of a change outside of physician ordered vital sign parameters.</p> <p>An interview was conducted with Certified Nursing Assistant 1 (CNA 1) on 12/28/24 at 10:59 A.M. CNA 1 stated CNAs were responsible for performing weights weekly and obtaining vital signs at the beginning of every shift. CNA 1 stated the information of weights and vital signs were then provided to the Licensed Nurses (LNs) for interpretation and documentation.</p> <p>An interview and record review was conducted with LN 1 on 12/18/24 at 11:05 A.M., regarding Resident 1. LN 1 stated if Resident 1's vital signs were outside of the parameters of the physician's orders, then there should be a note in Resident 1's record to indicate the physician was notified. LN 1 reviewed the nurses notes for the dates indicated on the MAR, of when the heart rate was greater than 90 beats per minute and the systolic blood pressure was less than 100. LN 1 stated there were no nurse's notes that indicated the physician had been notified and there should have been documentation the physician was notified. LN 1 stated vital sign parameters in Resident 1's case was important to identify early signs of sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). LN 1 stated weekly weights were important for nutrition and hydration monitoring. LN 1 stated if weights were not completed weekly as ordered by the physician, Resident 1 might be at risk of dehydration or fluid overload.</p> <p>An interview was conducted with LN 2 on 12/18/24 at 11:22 A.M. LN 2 stated if vital signs were outside of the physician's parameters and not reported to the physician, the physician was unaware of what was currently going on with the resident. LN 2 stated weekly weights were important for residents on fluid restrictions to identify if too much or too little fluids was ingested, which could complicate the recovery period.</p> <p>An interview and record review was conducted with the Director of Nursing (DON) on 12/18/24 at 11:23 P.M. The DON stated by not performing weekly weights as ordered by the physician, the resident could have an increase or decrease in weight and staff would be unaware. The DON reviewed Resident 1's weight sheet and stated the weights should have been completed and documented weekly, but they were not. The DON stated she expected staff to follow the physician's orders, related to vital sign parameters and if the vital signs were outside of those parameters, the physician should be notified, and it should be documented.</p> <p>According to the facility's policy, titled Acute Condition Changes-Clinical Protocol, dated March 2018, 1. The physician will help identify' individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter .or someone with unstable vital signs . Treatment/Management: 1. The physician will help identify and authorize appropriate treatments .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the facility's policy, titled Care Plans, Comprehensive Person-Centered, dated March 2022, . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and time frames; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physician, mental and psychological well-being .</p>		