STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055873	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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's nursing staff failed to maintain the dignity of one sampled resident (Resident 1) when Resident 1 arrived to the dialysis center (a facility where patients undergo a procedure to remove toxins from the blood) wearing only briefs and a blanket. This failure had the potential to cause the resident embarrassment and had the potential to lower self-esteem.Findings:During a record review on 6/13/25, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (kidney failure), and dependence on renal dialysis.During a record review on 6/13/25, the Physician's Orders indicated Resident 1 was taken to an outside dialysis center every Monday, Wednesday, and Friday.During a record review on 6/13/25, the Minimum Data Set (MDS- an assessment tool) indicated Resident 1 had a BIMS (Brief Interview for Mental Status- a tool to measure cognition, or mental processes such as memory, perception, decision making) of 00, which indicated his cognitive skills for daily-decision making were severely impaired.During a record review on 6/13/25, the Dialysis Communications form (a form used by the facility and dialysis center to communicate pertinent information about the resident such as vital signs, weight, medications given, etc) dated 6/9/25 indicated, Comments or special instructions post dialysis: .Pt [sic] arrived to clinic without gown [sic] just a blanket and his disposable brief.On 6/13/25 at 9 A.M., a telephone interview was conducted with the Dialysis Licensed Nurse (DLN) 1. DLN 1 stated he was familiar with Resident 1. DLN 1 stated Resident 1 had been a patient at the dialysis center for the past 4 years. DLN 1 stated he was on duty on 6/9/25 during Resident 1's dialysis treatment. DLN 1 stated Resident 1 arrived at the dialysis center wearing only disposable briefs, with a blanket over him. DLN 1 stated, .it's the first time that I witnessed [Resident 1 arriving without clothing]. He had a blanket on him, but its not enough. If that was my father, I'd be very upset. DLN 1 stated when Resident 1 still lived at home, and was transported to the dialysis center, .He always arrived fully dressed: shirt, pants, shoes. We were surprised he arrived like a newborn. There's no dignity in that. He was a [NAME] veteran, someone who served his time. DLN 1 stated dialysis typically lasted 3 to 4 hours. DLN 1 stated the temperature at the dialysis center was cold and he was worried Resident 1's comfort and blood pressure would be affected because he was only wearing briefs.On 6/13/25 at 10:16 A.M., an interview was conducted with Resident 2. Resident 2 stated she received dialysis at an outside dialysis center on Mondays, Wednesdays, and Fridays. Resident 2 stated she preferred to wear her own clothing to dialysis, and she would never go wearing only briefs. Resident 2 stated, .I don't want to go naked. It gets cold there.On 6/13/25 at 10:51 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was Resident 1's assigned CNA on 6/9/25 and got him ready for dialysis. CNA 1 stated on 6/9/25 she did not see any clothes in Resident 1's closet, but the facility had a clothing donation area. CNA 1 stated the clothes in the donation area were collected to use for residents who did not have personal clothing available. CNA 1 stated she did not offer clothing from the donation area to Resident 1. CNA 1 stated she dressed Resident 1 in a gown and disposable briefs to prepare him for dialysis on 6/9/25. CNA 1 stated she does not remember if Resident 1 removed his gown prior to going to dialysis.On 6/13/25 at 10:58 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 3. LN 3 stated prior to 6/9/25, she received reports from CNA's that Resident 1 would have episodes of removing his gown but she had never observed this behavior. LN3 stated she had observed Resident 1 remove his arm out of his gown, but did not know why. LN 3 stated there was no documentation that Resident 1 had a behavior of removing his clothing. On 6/13/25 at 11:44 A.M. a telephone interview was conducted with Resident 1's family member (FM) 1. FM 1 stated the dialysis center called her on [date] to let her know Resident 1 had arrived from the skilled nursing facility without clothes. FM 1 stated, I was [expletive for angry] when I heard about that.I thought, 'its not right.' FM 1 stated Resident 1 had two pairs of sweaters and two pairs of pants. FM 1 stated she would have brought Resident 1 more clothing if he needed it. FM 1 stated, If he took off the gown, he was probably uncomfortable. FM 1 stated her expectation was for the facility to call her if the resident needed clothing.On 7/11/25 at 11:50 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated clothing from the donation area should have been offered to Resident 1 if he did not have personal clothing available. The DON stated it was important to maintain resident dignity at all times.A review of the facility's policy titled Dignity revised 2/2021indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and