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	06/02/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide safe discharge teaching and caregiver training, including return demonstration and evaluation of the caregiver's ability to assist with activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), for one of three sampled residents (Resident 1) reviewed for discharge planning. As a result, the facility discharged Resident 1 to a hotel with a son identified as the primary caregiver despite concerns related to unstable housing, reported intoxication, lack of caregiver training, and failure to evaluate caregiver competency to safely meet Resident 1's 24-hour care needs. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing),cerebrovascular (CVA- stroke, loss of blood flow to a part of the brain) disease affecting left side, difficulty in walking, and need for assistance with personal care. A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/20/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 out of 15, which indicated Resident 1 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 1's MDS dated [DATE] with self-care indicated, Resident 1 required dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity or, more helpers are required for the resident to complete the activity).Shower/bathing: Required substantial/maximal assistance (Helper does does more than half the effort; helper lifts, holds, or supports trunk or limbs.Lower body dressing, and footwear: Required partial/moderate assistance (Helper does less than half the effort; helper lifts, holds, or supports trunk or limbs. Personal hygiene: Required partial/moderate assistance (Helper does less than half the effort; helper lifts, holds, or supports trunk or limbs). A record review of Resident 1's MDS dated [DATE] with mobility indicated, Resident 1 required dependent assistance with tub/shower transfer and walking 10 feet, partial assistance with toilet, chair/bed transfers and sit to lying. On 6/2/26 at 11:08 A.M., an interview and record review was conducted with the Social Service Assistant [SSA]. The SSA stated Resident 1 had been at the facility for several years, starting on 4/29/24, and was ultimately discharged on 5/2/26 to a hotel, identified as [HOTEL NAME].The SSA reviewed Resident 1's progress notes titled SOCIAL SERVICES PROGRESS NOTES dated 4/10/2026 at 11:01 A.M. indicated: .Resident's son approached social services requesting initiation of discharge planning. Son, [NAME], stated that he has cared for his mother throughout his life and is currently experiencing difficulty working with facility staff. He expressed a preference for his mother to return in his care. SS [Social, Services] spoke with the resident. The resident stated that if the facility could assist her temporarily until she receives her Social Security check, she would like to discharge to her son's home. The patient became tearful and expressed that she simply wanted to be with her son.The SSA further stated, she was aware the son stayed at hotels intermittently but did not believe he had a permanent home. The SSA stated that Resident 1 required 24-hour care and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	06/02/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility had attempted to locate placement in an assisted living (AL-a housing option where older adults live in private apartments but get help with daily tasks like cooking, cleaning, and taking medication) that could provide 24-hour care, but Resident 1 wanted a location where her son could also stay. The SSA stated there was no documentation Adult Protective Services (APS) was notified, despite concerns related to the son's unstable housing situation and Resident 1 being discharged to a hotel. A review of Resident 1's assessment titled INTERDISCIPLINARY [IDT-group of different experts who work closely together as one unit to formulate a plan of care]-DISCHARGE SUMMARY dated 5/2/26 indicated, .Skilled OT [occupational therapy] interventions provided this reporting period include ADL re-training incorporating compensatory strategies, body mechanics, and safety awareness; BUE[bilateral upper extremity] AROM [active range of motion]/strengthening open and closed kinetic chain[exercises or movements] ther-ex [exercise] for joint integrity/mobility and GMC [sic]; functional dynamic training for static/dynamic balance, functional reaching, postural control; and functional activity tolerance and aerobic capacity to improve functional endurance.Skilled PT interventions completed with focus on bed mobility training, transfer training, gait training, and patient education for safety awareness. However, there was no evidence (last progress noted from therapy 7/21/25-9/12/25) the facility completed or documented hands-on caregiver training, return demonstration, or competency evaluation to ensure Resident 1's son could safely provide the assistance required for Resident 1's ADLs and 24-hour care needs prior to discharge to a hotel setting (since notifying SS on 4/10/2026). On 6/2/25 at 12:14 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 1 had left-sided weakness from prior stroke (CVA) and although she (Resident 1) was able to move extremities (arms/hands, legs/feet), Resident 1's left side was weaker and slower to move. CNA 1 stated Resident 1 required increased assistance with transfers and mobility-related ADLs for safety. On 6/2/26 12:21 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was able to make her own decisions; however Resident 1 was not fully independent with ADLs. Resident 1 required assistance with ambulation (she was on Restorative Nursing for ambulation using parallel bars) and transfers for safety and was unable to walk independently due to left-sided weakness from a prior stroke.LN 1 stated Resident 1 required assistance with transferring and toileting and used a wheelchair for mobility. LN 1 stated she provided diabetic and medication education to Resident 1 prior to discharge, including insulin administration and blood pressure medication instructions on the day of discharge. LN 1 stated Resident 1 was not observed to determine if she could self-administer medications (i.e. insulin [medication of DM] injections) safely, stating, there was no return demonstration conducted for teaching. LN1 stated Resident 1 did not have physician orders for self-administration training prior to discharge. LN 1 stated because Resident 1's son was not present on the day of discharge, no caregiver teaching or return demonstration to evaluate safety was completed with Resident 1's son. LN 1 stated Resident 1's son should have participated in discharge teaching and safety monitoring. LN 1 stated Resident 1 would have been better in assisted living or community that provided around the clock care.LN 1 further stated concerns with son existed regarding the son's ability to safely provide care as he would get intoxicated and yes, this would be a safety issue as well. LN 1 stated staff previously smelled marijuana on the son during a facility visit which was noted in the progress notes on 8/31/25 at 19:47 (7:47 P.M.).On 6/2/26 at 1 P.M., an interview and record review was conducted with the Director of Rehab (DOR). The DOR stated Resident 1 continued to require assistance with toileting, transfers, ambulation and mobility and was not independently ambulatory. The DOR stated Resident 1 ambulated only with parallel bars and staff assistance. The DOR stated therapy staff did not re-evaluate Resident 1 for discharge readiness and did not complete caregiver training with Resident 1's son prior to discharge. The DOR stated, .No we did not pick her [Resident 1] up for therapy to re-evaluate for discharge and the need with Resident and care giver training with her son.The DOR stated Resident 1 would have been safer at an Independent Living (IL) or AL, or other 24-hour care wherever she went. The DOR stated Resident 1's son was expected to be the (continued on next page)

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	06/02/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	primary caregiver after discharge; however, the discharge summary did not contain evidence of caregiver training or return demonstration. The DOR stated, Care giver training is needed for safe discharge and carry over with family and to prevent injury, rehospitalization with discharge. The DOR further stated, We didn't provide any more training for a safe discharge (last progress noted from therapy 7/21/25-9/12/25). On 6/2/26 at 1:34 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 1's son notified the facility on 4/10/26, that he wanted Resident 1 discharged from the facility. The DON stated the discharge plan should have been updated with the IDT, including nursing and rehabilitation (rehab) services, to ensure a safe discharge process prior to Resident 1's discharge on [DATE].The DON further stated concerns existed regarding the son's behavior and its impact on safety within the facility. The DON stated the situation with the son raised safety concerns involving Resident 1's two female roommates. The DON stated stated I don't want to accuse that there were drugs involved, but he did show some signs in the past while he visited her. The DON stated she would have been safer for an AL or 24-hour care, the acknowledged that the son's behavior raised concerns related to Resident 1's safety and supervision.The DON stated the facility should have completed additional discharge teaching, including return demonstrations, to evaluate Resident 1's and caregiver's (son) ability to safely manage medications, treatments, and ongoing care needs after discharge, The DON stated caregiver training and return demonstrations were necessary to make sure the resident is safe on their own after they discharge from the facility. The DON stated Resident 1's son, identified as the primary caregiver after discharge, was not present at the time of discharge and no caregiver training or competency evaluation were completed with him prior to Resident 1 being discharged to a hotel setting. The DON stated, It could potentially harm the resident (Resident 1) without proper, safe discharge planning. On 6/3/26 at 3:22 P.M., an interview was conducted with the DON. The DON stated, APS was not called regarding concerns related to Resident 1's discharge. The DON stated social services provided information regarding in-Home Support Services (IHSS); however, the son reportedly needed identification documentation in order to apply for IHSS, and there was no evidence IHSS caregiver services were established or approved prior to discharge. The DON stated, I don't have any doubt that he could take care of his mom, but also acknowledged uncertainty regarding whether APS should have been contacted due to the circumstances surrounding the discharge. The DON stated, I'm in between resident's rights and safe discharge.The DON further stated the discharge process occurred quickly after Resident 1's son requested discharge from the facility. The DON stated staff wanted to get [Name of Resident 1's son] out of the facility to protect other residents, indicating concerns existed regarding the son's behavior and presence in the facility. A record review of Resident 1's clinical chart indicated no documented evidence of APS notification. A review of the facility's policy and procedure titled, Discharge Summary and Plan dated December 2016, indicated .Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan . The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and will include. arrangements that have been made for follow-up care and services.the degree of caregiver/support person availability, capacity and capability to perform required care.The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed .