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	02/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to prevent and treat three of five residents (Residents 99, 11 and 12) who were identified as being at risk of pressure injuries (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence) when: 1a. Resident 99 was not turned and repositioned every two hours; 1b. Resident 99 had missing entries on his daily wound treatment log; and 2. Resident 11 had missing entries on her daily wound treatment log; and 3. Resident 12 had missing entries on her daily wound treatment log. These failures had the potential for additional or worsening skin injuries to occur. 1a. Resident 99 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer (damage to the skin and tissue caused by prolonged pressure on the skin) of the left heel, Stage 4, (a full-thickness tissue loss that exposes bone, muscle, and/or tendon), per the facility's Admission Record. An observation was conducted of Resident 99, in his room on 2/10/25 at 9:04 A.M. Resident 99 was lying in bed, on his back with the head elevated on two pillows. Resident 99's left heel was elevated on a pillow and he was wearing a green padded protective boot. The bed had a regular mattress and a low air loss mattress (LAL-designed to distribute a patient's body weight over a broad surface area and helps prevent skin breakdown), was not present. An observation was conducted of Resident 99, in his room on 2/10/25 at 2:21 P.M. Resident 99 was asleep in bed, lying on his back with the head of the bed elevated at 20 degrees. Additional observations of Resident 99 were conducted on 2/11/25 at 8:12 A.M., 10:15 A.M., 10:58 A.M., 1:36 P.M., and 3:40 P.M. Resident 99 was lying on his back, in bed with the head of the bed slightly elevated. There appeared to be no changes in his position and no use of pillows to elevate pressure from his hips or back. Resident 99's clinical record was reviewed on 2/11/25: (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

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	02/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility's Braden Scale (a tool used to predict a patient's risk of developing pressure ulcers), dated 1/15/25, Resident 99 had a score of 13, indicating moderate risk for pressure injuries. A care plan, titled At Risk for Pressure Injury, dated 1/15/25, listed interventions such as: Turn and reposition every 2 hours and as needed. A care plan, titled Unstageable Pressure Injury Stage 4, left heel, revised 2/9/25, also listed interventions such as: Turn and reposition resident at least every 2 hours and as needed. According to the Minimum Data Set, (a clinical assessment tool) Section M-Skin Conditions, dated 1/21/25, Resident 99 was identified for being at risk of developing pressure injuries, with a treatment listed as, Being on a turning/repositioning program. An interview was conducted with Treatment Nurse 1 (Tx LN 1) on 2/12/25 at 8:03 A.M., after a wound treatment had been observed and completed for Resident 99. Tx LN 1 stated Resident 99 should be turned and repositioned ever two hours to prevent additional pressure injuries from occurring. Tx LN 1 stated Resident 99 did not have a LAL mattress and maybe he should have one. An interview and record review was conducted with Certified Nursing Assistant 1 (CNA 1) on 2/12/25 at 8:21 A.M. CNA 1 stated residents should be turned in bed at least every two hours to prevent skin injuries from occurring. CNA 1 stated CNAs documented repositioning residents every two hours in the computer charting system called Point of Care (POC). CNA 1 reviewed Resident 99's POC charting for 2/11/25, which indicated the resident was turned every two hours, starting at 8 A.M. with a yes response, but the system did not have an option for what position the resident was placed in, i.e right side, left side, pillow support etc. An interview was conducted with Licensed Nurse 1 (LN 1) on 2/12/25 at 8:27 A.M. LN 1 stated repositioning residents every two hours was important to prevent skin injuries from developing. LN 1 stated the Treatment Nurses (Tx LNs) could initiate a low air loss mattress request for residents, if they felt it was important and they did not need to wait for a physician's order. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 10:46 A.M. The DON stated she expected all residents to be turned and repositioned every two hours to prevent skin breakdown. According to the facility's policy, titled Prevention of Pressure Injuries, dated April 2020, .Skin Assessment: .3 e. Reposition resident as indicated on the care plan .Mobility/Repositioning: 1. Reposition all residents with a risk of pressure injuries on an individual schedule .Support Surfaces and pressure Redistribution: 1. Select appropriate support surfaces based on the resident's risk factors . 1b. Resident 99 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of the left heel, Stage 4, (a full-thickness tissue loss that exposes bone, muscle, and/or tendon), per the facility's Admission Record. (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	02/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted of Resident 99, in his room on 2/10/25 at 9:04 A.M. Resident 99 was lying in bed, on his back with his head elevated on two pillows. Resident 99's left heel was elevated on a pillow and he was wearing a green protective boot. Resident 99's clinical record was reviewed on 2/11/25: According to Resident 99's Minimum Data Set, (a clinical assessment tool) Section M-Skin Conditions, dated 1/21/25, Resident 99 was admitted with one Stage 4 pressure ulcer that required dressing changes and ointment/medication, along with pressure injury care. According to Resident 99's physician's order, dated 1/22/25, .cleanse (Stage IV pressure injury) on Left Heel with normal saline, pat dry, apply Santyl (an enzyme/protein that breaks down collagen in damaged or dead skin), alginate (a highly absorbent dressing used for wounds that are draining, bleeding, or infected) and cover with dry dressing every day and as needed . According to Resident 99's care plan, titled Unstageable Pressure Injury Stage 4, left heel, revised 2/9/25, interventions listed: Evaluate skin condition on a daily basis, Treatment/medication as ordered. Heel boot to be worn as ordered, and turn and reposition resident at least every 2 hours and as needed. According to Resident 99's Treatment Administration Record (TAR), dated January 21 through January 31, 2025, Resident 99 had no wound treatments performed for four of 10 days. Resident 99's wound treatments were missed on 1/26/25 (Sunday), 1/27/25 (Monday), 1/29/25 (Wednesday) and 1/30/25 (Thursday). An interview and record review was conducted with The Treatment Nurse 1 (Tx LN 1) on 2/12/25 at 8:03 A.M. , after observing Resident 99's daily wound treatment. The Tx LN 1 stated Resident 99's wound was improving, and the wound physician was examining the resident every Wednesday with wound measurements being performed. The Tx LN 1 reviewed Resident 99's January 2025 Treatment Administration Record (TAR), and stated he believed the staff just forgot to check off the treatment as being performed, for those four days. The TX LN 1 stated if the treatment was not documented, then no one knew for sure if the treatment was actually completed. The Tx LN 1 stated daily wound treatments were important to provide consistent care and to inspect the wound for signs of infection or a worsening condition. The TX LN 1 stated wound treatments should always be documented, to ensure they were completed as ordered. An interview was conducted with Licensed Nurse 1 (LN 1) on 2/12/25 at 8:37 A.M. LN 1 stated all wound treatments needed to be documented, so other staff knew it was completed. LN 1 stated daily wound treatments were important to help with healing and to identify early signs of infection. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 10:46 A.M. The DON stated if a wound treatment was not documented on the TAR, then it was not done, The DON stated she expected all wound treatments to be performed as ordered by the physician. According to the facility's policy, titled Prevention of Pressure Injuries, dated April 2020, .Monitoring: 1. Evaluate, report, and document . (continued on next page)

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 02/13/2025
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility's policy, titled Charting and Documentation, dated 2020, .2. the following information is to be documented in the resident medical record .c. Treatments or services performed . 48270 2. Resident 11 was admitted to the facility on [DATE] for physical therapy related to difficulty walking per the History and Physical. On 1/22/25, Resident 11 was noted with a right heel ruptured blister, per the wound consult note dated 1/22/25. On 2/10/25, at 8 A.M., an observation was conducted in Resident 11's room. Resident 11 was lying down on the bed and was noted to have a low air loss (LAL) mattress (a mattress designed to help prevent skin breakdown). Resident 11's right foot was noted to be elevated on pillows. A review of Resident 11's clinical record was conducted on 2/11/25. According to Resident 11's physician's order dated 1/30/25, the physician ordered to Paint Deep Tissue Injury (DTI - damage to the tissues underneath the skin, usually caused by prolonged pressure on a bony area) on right heel with Betadine (antiseptic for the treatment of common skin infections and leave open to air dry daily . According to the Treatment Administration Record (TAR), dated February 1 through February 12, 2025, Resident 11 had no wound treatments performed for two of the 12 days. Resident 11's wound treatments were missed on 2/5/25 (Wednesday) and 2/8/25 (Saturday). On 2/12/25, at 2 P.M., a concurrent interview and record review was conducted with Treatment Nurse 1 (Tx LN 1). The Tx LN 1 reviewed Resident 11's February 2025 Treatment Administration Record (TAR), and stated he believed the staff just forgot to check off the treatment as being performed, for those two days. The Tx LN 1 stated if the treatment was not documented, then no one knew for sure if the treatment was actually completed. The Tx LN 1 stated wound treatments should always be documented, to ensure they were completed as ordered. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 2:30 P.M. The DON stated if a wound treatment was not documented on the TAR, then it was not done. The DON stated she expected all wound treatments to be performed as ordered by the physician. According to the facility's policy, titled Prevention of Pressure Injuries, dated April 2020, .Monitoring: 1. Evaluate, report, and document . According to the facility's policy, titled Charting and Documentation, dated 2020, .2. the following information is to be documented in the resident medical record . Treatments or services performed . 3. Resident 12 had missing entries on her daily wound treatment log. Resident 12 was admitted to the facility on [DATE] with diagnoses that included stage 4 pressure ulcer of the left buttock and stage 4 pressure ulcer of the right hip, per the facility's Admission Record. (continued on next page)

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 02/13/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25, a review of Resident 12's clinical record was conducted. According to Resident 12's physician's orders dated 1/15/25, the physician order to 1) cleanse stage 4 pressure injury on left buttock with normal saline .and cover with dry dressing daily . 2) cleanse stage 4 pressure injury on right hip with normal saline .and cover with dry dressing daily . According to Resident 12's Treatment Administration Record (TAR), dated February 1 through February 12, 2025, Resident 12 had no wound treatments performed for three of the 12 days. Resident 12's wound treatments were missed on 2/4/25 (Tuesday), 2/5/25 (Wednesday) and 2/8/25 (Saturday). On 2/12/25, at 2:15 P.M., a concurrent interview and record review was conducted with Treatment Nurse 1 (Tx LN 1). The Tx LN 1 reviewed Resident 12's February 2025 Treatment Administration Record (TAR), and stated he believed the staff just forgot to check off the treatment as being performed, for those two days. The Tx LN 1 stated if the treatment was not documented, then no one knew for sure if the treatment was actually completed. The Tx LN 1 stated wound treatments should always be documented, to ensure they were completed as ordered. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 2:30 P.M. The DON stated if a wound treatment was not documented on the TAR, then it was not done. The DON stated she expected all wound treatments to be performed as ordered by the physician. According to the facility's policy, titled Prevention of Pressure Injuries, dated April 2020, .Monitoring: 1. Evaluate, report, and document . According to the facility's policy, titled Charting and Documentation, dated 2020, .2. the following information is to be documented in the resident medical record . Treatments or services performed .

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 02/13/2025
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to administer the correct amount of oxygen, according to the physician's order for one of two residents (Resident 99), reviewed for oxygen therapy. This failure had the potential for too much carbon dioxide to accumulate in the blood, affecting the body's blood pH, respiratory drive, and the blood cells affinity for oxygen. Findings: Resident 99 was admitted to the facility on [DATE], with diagnoses which included chronic (persisting for a long time) respiratory failure with hypoxia (insufficient amount of oxygen in the body's tissues) and encounter for attention to tracheotomy (a surgical procedure that creates an opening in the front of the neck [trachea] in order to provide an airway), per the facility's Admission Record. An observation was conducted of Resident 99 on 2/10/25 at 9:01 A.M. as he laid in bed. Resident 99 had a stoma (a surgical opening in the neck that allows a person to breathe without a tube inserted). The stoma was covered with an oxygen mask and tubing, attached to a oxygen concentrator (a medical device that supplies oxygen-enriched air) was on the floor, beside the bed. The oxygen condenser dial was set at 5, indicating it was delivering 5 liters (a unit that expresses flow rate) of oxygen per minute. An observation was conducted of Resident 99, in his room on 2/11/25 at 8:12 A.M. Resident 99's concentrator oxygen concentrator flow rate was set at 5 liters per minutes (LN/min), and an oxygen mask was over his stoma. Resident 99's clinical record was reviewed on 2/11/25: According to the physician's order, dated 1/15/25, .Respiratory: administer oxygen at 2 LN/min via trach mask continuously. Diagnoses: Acute hypercarbic (a serious condition that occurs when there is too much carbon dioxide in the blood), respiratory failure status post laryngectomy (a surgical procedure to remove their larynx [voice box], resulting in a permanent opening in the neck called a stoma through which they breathe), every shift . According to the care plan, titled Oxygen Therapy, dated 1/15/25, listed interventions such as; Oxygen Setting: The resident has O2 (oxygen) via trach mask at 2 L/min continuously. According to the facility's oxygen saturation rates (a measurement of the percentage of hemoglobin in the blood that carry's oxygen), documented from 1/15/25 through 2/10/25, the saturation rates ranged from 97% to 99% on room air (Normal 95% to 100%). (continued on next page)

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 02/13/2025
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation, interview, and record review was conducted with Licensed Nurse (LN) 1 of Resident 99's oxygen order and rate on 2/12/25 at 7:19 A.M. LN 1 stated the physician's order indicated Resident 99 was to receive oxygen at 2 L/min via his trach mask, continuously. LN 1 went into Resident 99's room to inspect the oxygen flow rate on the concentrator. LN 1 stated the oxygen was delivering 5 L/min, which was wrong. LN 1 stated by providing more oxygen then ordered, Resident 99 was at risk of having too much carbon dioxide in the blood stream. An interview was conducted with respiratory therapist 1 (RT 1- a licensed health professional who helps residents with breathing problems) on 2/12/25 at 7:45 A.M. RT 1 stated Resident 99 was bypassing his upper airway and breathing through his lower airway. RT 1 stated she expected the licensed nurses to following the physician's order on how much oxygen was being administered. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 10:46 A.M. The DON stated she expected the licensed nurses to follow the physician's order and to contact the physician if oxygen orders needed to be clarified. The DON stated too much oxygen could cause harm and lead to hypercarbic. According to the facility's policy, titled Oxygen Administration, dated October 2010, .Preparation: 1. Verify that there is a physician's order .Review the physician's order .Documentation: .The following information should be recorded in the resident's medical record .3. The rate of oxygen flow, route, and rationale .

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 02/13/2025
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)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49330 Based on observation, interview, and record review the facility failed to ensure the kitchen staff competently performed and carried out the functions of the Food and Nutrition Service department when [NAME] 1 could not properly demonstrate how to calibrate a food thermometer, when reviewed for competency. This failure had the potential for food contamination, resulting in food borne illnesses for all residents who consumed food from the kitchen. Findings: During a joint observation and interview on 2/12/25 at 10:52 A.M. with [NAME] 1, [NAME] 1 was asked to demonstrate how to properly calibrate an analog thermometer (device that measures temperature by using mercury or alcohol). [NAME] 1 began to twist the thermometer's probe and stated, .I have to move the line [dial] to 0 [degrees Fahrenheit] then I put it in the water .you don't need to put it in the water if its already on 32 degrees . On 2/13/25 an interview was conducted with the Dietary Supervisor (DS). The DS stated it was his expectation for all kitchen staff to know how to calibrate thermometers properly, whether it is a digital or analog thermometer. The DS stated it was important to use a calibrated food thermometer to obtain an accurate food temperature reading. The DS stated, We use food thermometers to take food temperatures, to make sure nothing is undercooked. We don't want anyone to get sick. A review of the facility policy titled, Thermometer Use and Calibration, dated 2023 indicated, Checking the Accuracy and Calibrating .1. Fill a large class with crushed ice and add clean tap waster until slush is formed. Stir the mixture well .2. Put the thermometer's stem into the ice water so that the sensing area is completely submerged .The thermometer stem or probe must remain in the ice water one minute and during calibration process. 3. If the thermometer does not read 32 degrees Fahrenheit then the thermometer must be calibrated .Bimetal or analog thermometer .turn the face of the dial until the indicator is at 32 degrees .

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 02/13/2025
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49330 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices were met in the kitchen according to standards of practice, when two green cutting boards with deep cuts and food stains were stored in the clean area. In addition, one red cutting board and one brown cutting board with deep cuts were also stored in the clean area, when reviewed for food sanitation. This failure exposed residents to contaminated food surfaces and unsanitary practices, which had the potential to place them at risk of developing foodborne illness. Findings: On 2/12/25 at 11:13 A.M. an observation and interview was conducted with Dietary Worker 1 (DW 1). A green chopping board was observed on the kitchen counter, next to the 3-compartment sink. The cutting board had multiple knife cuts and scratches on both sides. There were dark brown colored stains visible in the scratches and on the chopping board surface. DW 1 stated the cutting board had just been washed and was in the drying area. A second green chopping board was observed hanging above the 3-compartment sink, and had brownish stains and knife cuts on both sides. One red chopping board and one brown chopping board, both stored in the clean area, were observed with deep knife cuts. DW 1 stated, This [the green chopping board] needs to be changed. On 2/13/25 at 8:13 A.M., an interview was conducted with the Food Services Director (FSD). The FSD stated, It's important health wise not to use a cutting board that is stained .there's residue on it and in the cuts. We want to avoid contamination . According to the 2022 Federal FDA Food Code, section 4-501.12, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces . A review of the facility policy titled Sanitation, dated 2023 indicated, .11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas .2. Plastic ware .that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining .

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 02/13/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, ad record review, the facility failed to accurately document antibiotic (drugs which treat infections) administration in one of two residents (Resident 88) clinical record, when reviewed for Antibiotic Therapy. This failure had the potential for Resident 88's clinical record to be incomplete and inaccurate. Findings: Resident 88 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis (a bone infection) of the thoracic (upper spine) and lumbar (lower spine), region, per the facility's Admission Record. An observation was conducted of Resident 88 in his room on 2/10/25 at 10:17 A.M. Resident 88 was asleep in bed and an intravenous (IV-a medication bag which delivers fluid and medication to a vein) bag was infusing via an IV pump (a machine which delivers a certain amount of medication per minute). The exterior door to the resident's room was labeled as Contact precautions (infection control measures used to prevent the transmission of infectious agents that are spread through direct or indirect contact with an infected resident). Resident 88's clinical record was reviewed on 2/11/25: According to the physician's order dated 1/14/25, Contact precautions: related to positive for MRSA (Methicillin-resistant Staphylococcus aureus-a bacteria that is resistant to many antibiotics) and osteomyelitis. An additional physician's order dated 1/25/25, listed medications: Daptomycin (A drug used to treat certain bacterial bloodstream infections) 500 milligrams (mg) IV one time a day until 4/1/25, infuse over 1 hour, and Teflaro (an antibiotic used to treat infections) 600 mg two times a day for osteomyelitis, until 4/1/25, over 60 minutes. According to the Medication Administration Record, (MAR), reviewed from 1/25/25 through 1/31/25, Daptomycin 500 mg was not administered, on 1/28/25, at 6 P.M., and Teflaro was not administered on 1/28/25 for the evening dose (10 p.m.), as ordered. According to the care plan, titled MRSA in/on back, dated 1/14/25, listed interventions such as: Administer medications as ordered and contact isolation. According to the care plan, titled IV antibiotic therapy related to infection, dated 1/10/25, listed interventions such as: Administer medications as ordered (Daptomycin, Teflaro). Observe for possible side effects every shift. (continued on next page)

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 02/13/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with Licensed Nurse 2 (LN 2) on 2/11/25 at 4:07 P.M. of Resident 88's MAR. LN 2 stated according to the MAR, Resident 88 did not receive his IV antibiotics on 1/25/25, as ordered by the physician. LN 2 stated the LNs should have documented why the medication was not given, and there was no documented notes, such as the medication had not been delivered or the resident was not in the facility. LN 2 stated Resident 88's antibiotic administration needed to be consistently administered, to maintain the medication threshold for fighting the infection. An interview and record review was conducted with LN 1 on 2/12/25 at 8:31 A.M. LN 1 acknowledged the missing IV medication entries in Resident 88's MAR for 1/28/25. LN 1 stated it was important to administer the medication consistently, so the medication was effective. LN 1 stated the facility had a separated IV Administration Record, and asked if she could retrieve it from the Medical Records Department. An interview and record review of the facility's IV Administration Record book for Resident 88 was conducted with LN 1 on 2/12/25 at 8:56 A.M. The handwritten entries indicated Daptomycin was administered on 1/28/25 at 6 P.M., and Teflaro was administered on 1/28/25 at 10 P.M. LN 1 stated it was important for the IV book to match the electronic MAR, so Resident 88's clinical record was accurate. LN 1 stated if someone just looked at the MAR, it appeared the medication was never administered. An interview was conducted with the Director of Nursing (DON) on 2/12/25 at 10:46 A.M. The DON stated she expected the MAR to match the IV Administration book, so the documentation was accurate and complete. According to the facility's policy, titled Charting and Documentation, dated 2020, .2. the following information is to be documented in the resident medical record: .b. Medications administered; c. Treatments or services performed .