STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A109	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	2335 S. Mountain Ave Duarte, CA 91010

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50203 Based on interview and record review, the facility failed to ensure one of two smapled residents (Resident 3) was monitored and document for episodes of mood instability every shift due to resident's history of verbal aggression towards facility staff members as indicated in the plan of care and the facility's policy and procedure while receiving psychotropic medications (medication that affects mood and behavior). This failure resulted in Resident 3's continued verbal aggression towards the facility staff and physical aggression towards his roommate (Resident 2) and a potential to be a danger other residents and staffs that could result in injuries. This could also result in the resident not receiving the proper dosage of medications needed to control his behavior. Findings: A facility reported incident was received on 8/7/24 at 8 AM regarding Resident 3 hitting Resident 2 on the face twice with closed fist when Resident 2 spilled juice on the floor. During a review of Resident 2's Admission Record (Face Sheet), indicated the facility admitted Resident 2 on 12/13/2013 and readmitted him on 12/15/2023 with diagnoses that included schizophrenia (a serious mental disorder that affects how a person thinks, feels, and behaves), anxiety disorder (a condition that causes people to experience excessive and irrational worry, fear, dread, and uneasiness that can interfere with daily living). During a review of Resident 2's History Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the resident's health status), dated 9/22/2023, indicated Resident 2 has a history of mental illness (a medical condition that causes changes in a person's thinking, feeling, or behavior) and substance abuse. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/25/2024, indicated Resident 3 was cognitively (a person's ability to think, learn, remember, use judgement, and make decisions) intact. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Face Sheet, indicated the facility admitted Resident 3 on 3/6/2024 with diagnoses that included paranoid schizophrenia (a mental disorder in which a person has extreme fear and distrust of others) and hypertension (high blood pressure). During a review of Resident 3's HPE, dated 3/6/2024, indicated Resident 3 had a history of prior traumatic brain injury with underlying cognitive impairment and mental illness. During a review of Resident 3's Order Summary Report, dated 8/7/2024, indicated the physician ordered on 3/6/2024 for Resident 3 to be monitored for number of episode for mood stabilization m/b [manifested by] going from calm and cooperative to verbal aggression. During a review of Resident 3's care plan (a document that outlines the facility's plan to provide personalized care a resident based on the resident's needs), last revision dated 8/7/2024, indicated the resident has behavior problem r/t [related to] mood stabilization as m/b [manifested by] going from calm and cooperative to verbal agitation. The care plan indicated on 8/6/2024 Resident 3 suddenly approached his roommate and hit him twice on the head and face with closed fist when Resident 3's roommate spilled juice on the floor. The care plan's intervention indicated to monitor Resident 3 for mood instability every shift. During a review of Resident 3's Medication Administration Record (MAR) and clinical record indicated no evidence from 7/2024 and 8/2024 that Resident 3's episodes of verbal aggression were monitored. During an interview on 8/8/2024 at 1:49PM with Resident 3's Program Counselor (PC) 1, PC 1 stated Resident 3's baseline behavior was normally calm. PC 1 stated the only thing that triggers Resident 3's aggressive behavior was when showering on shower day. PC 1 stated Resident 3 also had aggressive behavior by yelling, cursing, and following the nurses' around saying I showered yesterday or please let me just have a cigarette. PC 1 stated Resident 3 would do this for about 15 minutes before agreeing to take a shower. During an interview on 8/8/2024 at 2:17PM with CNA 1, CNA 1 stated the only issues with Resident 3 happened around shower day. CNA 1 stated Resident 3 yells and say let me shower tomorrow and calls CNA1 with disrespectful names. During a concurrent interview and record review on 8/8/2024 at 2:20PM with Licensed Vocational Nurse (LVN) 1, Resident 3's MAR and other clinical records were reviewed. LVN 1 stated Resident 3'sepisodes of aggressive behaviors of was shouting and cursing towards the staff during shower days were not monitored and documented to in the MAR and the clinical records to help evaluate if there was escalation of aggressive behavior and what non pharmacological (no use of medications) were implemented to help resident to calm down. During a concurrent interview and record review on 8/8/2024 at 2:40PM with the Registered Nurse (RN) 1, Resident 3's MAR and nursing progress notes were reviewed. RN 1 stated today [8/8/2024] Resident 3 had an episode of verbal aggression and should have been documented. RN 1 stated if Resident 3 has been verbally aggressive towards staff around shower days, these episodes should be documented to monitor for escalation of aggressive behavior towards staff and other residents. RN 1 stated there was no documented evidence Resident 3'aggressive behaviors was being monitored. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/8/2024 at 3:15PM with the Director of Nursing (DON), Resident 3's MAR and the resident's clinical record were reviewed. The DON stated the definition of verbal aggression was shouting and yelling. The DON stated Resident 3' aggression towards his roommate should have been documented in the progress notes and the MAR to indicate that behavior was monitored for mood instability every shift and every episode by the nurses when it happened on 8/6/24. During a review of the facility's policies and procedures titled, Antipsychotic Medication Use, last revised 7/2022, indicated the attending physician and other staff will document information to clarify the resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.