

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</p> <p>Based on observation, interview, and record review, the facility failed to protect a resident ' s right to be free from physical abuse for one of three sampled residents (Resident 5).</p> <p>Certified Nursing Assistant (CNA) 1 reported witnessing Program Counselor (PC) 1 hit the face of Resident 5, who had a diagnosis of unspecified mood (affective) disorder (group of conditions of mental and behavioral disorder where a disturbance in the person ' s mood is the main underlying feature), autistic disorder (neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), and mild intellectual disabilities (slower in all areas of conceptual development and social and daily living skills), after Resident 5 began punching PC 1 on 7/30/2024.</p> <p>This deficient practice resulted in Resident 5 to experience physical abuse from PC 1.</p> <p>Findings:</p> <p>A review of Resident 5 ' s Admission Record indicated an admission to the facility on [DATE] with diagnoses including unspecified mood (affective) disorder, autistic disorder, and mild intellectual disabilities.</p> <p>A review of Resident 5 ' s Minimum Data Set (MDS, an assessment and screen tool) dated 5/26/2024 indicated Resident 5 had moderately impaired cognition (the ability or mental action or process of acquiring knowledge and understanding).</p> <p>A review of staff statement from CNA 1 dated 7/31/2024 indicated Resident 5 started attacking and punching PC 1. CNA 1 ' s statement indicated PC 1 retaliated and punched Resident 5 in the face which cause resident ' s nose to bleed.</p> <p>A review of staff statement from PC 1 dated 7/30/2024 indicated PC 1 left the dining room area and into the courtyard when Resident 5 was observed with CNA 1 for line of sight supervision. PC 1 ' s statement indicated Resident 5 was agitated, pushed PC 1, and began yelling profanities. PC 1 ' s statement indicated Resident 5 postured with a closed fist and attempted to hit PC 1. PC 1 ' s statement indicated there was no contact and PC 1 tried to defend himself from Resident 5 ' s attack.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 5 on 8/12/2024 at 1:24 PM, Resident 5 stated PC 1 hit his nose. Resident 5 he tried to fist bump PC 1. Resident 5 stated he pushed PC 1, but could not recall what caused him to push PC 1. Resident 5 stated he had pain on his hand and face and was taken back to his room because his nose was bleeding. Resident 5 stated he feels safer now that PC 1 is not at the facility. Resident 5 stated after PC 1 hit him, he made me feel bad. Resident 5 looked upset and could not elaborate what bad meant.</p> <p>During an interview with CNA 1 on 8/12/2024 at 3:20 PM, CNA 1 stated while he was covering as Resident 5 's line of sight (LOS - monitoring/supervising the resident one-on-one) staff during breaktime, Resident 5 started punching PC 1 like making a fist bump and PC 1 refused to give Resident 5 a fist bump. CNA 1 stated as he and Resident 5 were walking out of the Dining Room, Resident 5 saw PC 1 and started to attack PC 1 by punching him. CNA 1 stated PC 1 fought back to defend himself and punched Resident 5 in the face which cause the resident ' s nose to bleed. CNA 1 stated he tried to stop Resident 5, but everything happened so fast. CNA 1 stated PC 1 only punched Resident 5 once. CNA 1 stated that according to facility practice, when a staff is providing LOS for a resident, there was no exact distance how close the LOS staff to the resident. CNA 1 stated he was less than three feet away from Resident 1 when the incident between Resident 1 and PC 1 happened.</p> <p>During a concurrent interview and record review of the facility's investigation with the facility's Program Director (PD) on 8/12/2024 at 3:33 PM, PD stated she read the investigation report and knew something was wrong. The PD stated when she saw the investigation indicated self injury she knew that there was something going on because the resident would not harm himself, he just scratches himself and he gets scabs, but he would not punch himself in the face. The PD stated she found out PC 1 hit Resident 5 in the face. The PD stated she did not understand the reaction PC 1 had because facility staff were all all instructed to walk away during situations like that. The PD stated she informs facility staff all the time to walk away when resident situations are escalating, becauser staff should know when to deescalate.</p> <p>A review of facility ' s policy and procedure (P&P) titled Abuse Prevention Program, dated 8/2021 indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P&P indicated as part of the resident abuse prevention, the administration will protect the residents from abuse by anyone including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</p> <p>Based on observation, interviews and record review, the facility failed to report an allegation of abuse to the Department and other officials immediately, but not later than two hours for one of three sampled residents (Resident 5) in accordance with the mandated Federal and State regulatory guidelines.</p> <p>This deficient practice had the potential for the facility to under report allegations of abuse, which could lead to failure to investigate alleged abuse in a timely manner.</p> <p>Findings:</p> <p>A review of Resident 5 ' s Admission Record indicated an admission to the facility on [DATE] with diagnoses including unspecified mood (affective) disorder, autistic disorder, and mild intellectual disabilities.</p> <p>A review of Resident 5 ' s Minimum Data Set (MDS, an assessment and screen tool) dated 5/26/2024 indicated Resident 5 had moderately impaired cognition (the ability or mental action or process of acquiring knowledge and understanding).</p> <p>A review of the staff statement from Certified Nursing Assistant (CNA) 1 dated 7/31/2024 indicated Resident 5 started attacking and punching PC 1. CNA 1 ' s statement indicated PC 1 retaliated and punched Resident 5 in the face which cause resident ' s nose to bleed.</p> <p>A review of the staff statement from PC 1 dated 7/30/2024 indicated PC 1 left the dining room area and into the courtyard when Resident 5 was observed with CNA 1 for line of sight supervision. PC 1 ' s statement indicated Resident 5 was agitated, pushed PC 1, and began yelling profanities. PC 1 ' s statement indicated Resident 5 postured with a closed fist and attempted to hit PC 1. PC 1 ' s statement indicated there was no contact and PC 1 tried to defend himself from Resident 5 ' s attack.</p> <p>During an interview with Licensed Vocational Nurse (LVN) 1 on 8/12/2024 at 3:07 PM, LVN 1 stated he spoke with PC 1 who sstated Resident 5 was lying. LVN 1 stated he did not report the incident as abuse to CDPH, law enforcement and the Ombudsman, because PC 1 informed him that Resident 5 ' s injury to the nose was self-inflicted. LVN 1 stated that In any case of abuse he would notify the facility supervisor, the Administrator, the DON and also notify CDPH, law enforcement and the Ombudsman within two hours.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of the facility's investigation with the facility's Program Director (PD) on 8/12/2024 at 3:33 PM, PD stated she read the investigation report and knew something was wrong. The PD stated when she saw the investigation indicated self injury she knew that there was something going on because the resident would not harm himself, he just scratches himself and he gets scabs, but he would not punch himself in the face. The PD stated she found out PC 1 hit Resident 5 in the face. The PD stated she did not understand the reaction PC 1 had because facility staff were all all instructed to walk away during situations like that. The PD stated she informs facility staff all the time to walk away when resident situations are escalating, becauser staff should know when to deescalate.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-reporting and investigating, dated 9/2022 indicated if abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>The P&P indicated immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</p> <p>Based on interview and record review, the facility failed to provide supervision for one of six sampled residents (Resident 6) who was at risk at risk for elopement.</p> <p>As a result, Resident 6 was able to leave the facility and was Absent Without Leave (AWOL) from the facility on 8/1/2024. Resident 6 was found by local law enforcement walking back towards the facility on the same day.</p> <p>This failure had the potential for Resident 6 to sustain serious injuries that could result in the decline in the resident ' s well-being.</p> <p>Findings:</p> <p>A review of Resident 6 ' s Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included bipolar disorder (mental illness that causes unusual shifts in a person ' s mood, energy, activity levels, and concentration), oppositional defiant disorder (behavior disorder diagnosed in childhood that show a pattern of uncooperative defiant, and hostile behavior toward peers, parents, teachers, and other authority figures), and attention deficit, hyperactivity disorder (ADHD, chronic condition including attention difficulty, hyperactivity, and impulsiveness).</p> <p>A review of Resident 6 ' s Minimum Data Set (MDS - a standardize assessment and care screening tool) dated 4/23/2024 indicated Resident 6 had moderately impaired cognition (the ability or mental action or process of acquiring knowledge and understanding).</p> <p>A review of Resident 6 ' s Elopement Risk assessment dated [DATE] indicated the resident was at risk for elopement.</p> <p>A review of Resident 6 ' s Progress Notes dated 8/1/2024 timed at 11:28 AM indicated at approximately 10:05 AM, Resident 6 was on the way to see the dentist in the facility ' s main building accompanied by his line of sight (LOS, supervision) staff. The Progress Note indicated while walking, Resident 6 saw an opportunity of a gate open and began running towards the gate and left the facility premises. The Progress Note indicated a Code [NAME] was announced, but Resident 6 got out of the gate and ran towards the street. The Progress Note indicated at 10:30 AM, the local law enforcement found Resident 6 walking back to the facility. The Progress Note indicated Resident 6 was calm and cooperative, body check was done and no injuries were noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Certified Nursing Assistant (CNA) 2 on 8/12/2024 at 2:29 PM, CNA 2 stated she was assigned as Resident 6 ' s LOS on 8/1/2024. CNA 2 stated she accompanied Resident 6 to walk and see the dentist in the facility ' s main building. CNA 2 stated when she and Resident 6 were returning back to Resident 6's room which was located to another building within the facility, Gate 1 (gate opening to the street) and Gate 2 (gate opening between main building and bungalow building) were opened (unlocked) because of a delivery at the facility's kitchen. CNA 2 stated Resident 6 saw both gates were opened for the kitchen delivery and ran towards Gates 1 and 2. CNA 2 stated she yelled for help to tell everyone that Resident 5 ran and left the facility premises.</p> <p>During an interview with the Dietary Supervisor (DS) on 8/12/2024 at 4:21 PM, the DS explained the facility's process during kitchen deliveries. The DS stated that the dishwasher attendant (DA) opens the gate for kitchen deliveries. The DS stated when there is a delivery, someone from the kitchen (DA or stockperson) would open the gates (Gates 1 and 2) and watch until the delivery is complete. The DS stated the responsibility of the DA or stockperson was to (1) open Gate 2 and lock Gate 2. The DDS stated that the second responsibility was to open Gate 1 for delivery trucks so that the food pallets could be brought into the Maintenance Area by the delivery staff. The DS stated that while Gate 1 would be left open, the DA/stockperson would walk back to open Gate 2 again and stand at Gate 2 to make sure there was supervision for Gate 2 (because it is open). The DS stated DA/stockperson should supervise Gate 2 to make sure residents do not elope and get out from Gate 2. The DS stated supervision of Gate 2 should be done for resident safety.</p> <p>During an interview with the maintenance assistant (MA) on 8/12/2024 at 5:32 PM, the MA stated at the time, the MA was sitting outside of maintenance office when he saw Resident 6 ran out so fast out of Gate 1, on 8/1/2024. The MA stated there was a kitchen delivery at that time. The MA stated there should have been a kitchen staff supervising Gate 2, but he did not see any staff standing by at Gate 2 when Resident 6 ran out. The MA stated when there is a kitchen delivery, it was the responsibility of the kitchen staff to open the gates and supervise the gates (Gates 1 and 2).</p> <p>During an interview with the DS on 8/12/2024 at 6:00 PM, the DS stated she was in the office inside the kitchen when Resident 6 had the AWOL. The DS stated it was the responsibility of the DA/stockperson to supervise Gate 2, to be there and make sure no residents leave the facility through the opened Gates 1 and 2. The DS stated she did not know exactly what happened as her kitchen staff did not discuss with her. The DS stated the only thing the DA told her was that the gate was open and Resident 6 bolted. The DS stated the DA did not tell her where he was standing by when Resident 6 ran out of Gates 1 and 2. The DS stated she did not investigate further where the DA was on 8/1/2024 when Resident 6 ran out of the opened gates.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Wandering and Elopements, dated 3/2019 indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>A review of the facility ' s P&P titled Supervision and Precautions, dated 2/21/2022 indicated daily supervision/suicide precautions/dangerous behavior precautions, non-consensual sexual behavior and medical precautions are actions taken by the nursing/program staff to protect patient from suicidal gestures and/or attempts of dangerous behavior, medically stable and to ensure observation of the patient.</p>		