

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 10/09/2024
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>47467</p> <p>Based on interviews and record reviews, the facility staff failed to implement the facility ' s policy and procedure, titled Abuse, neglect, Exploitation or Misappropriation - Reporting and Investigating, by identifying, protecting, reporting, and initiating an investigation immediately from a suspected sexual abuse allegation brought up by a resident to the facility staff on 9/30/2024 and 10/6/2024, for one of two sampled residents (Resident 1).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Identify an allegation of sexual abuse by unknown men reported by Resident 1 on 9/30/2024 and 10/6/2024. 2. Report Resident 1 ' s allegation of sexual abuse by unknown men to the California Department of Public Health, local law enforcement, Ombudsman (state agency that advocates for the residents) and Adult Protective Services (agency that protects the adults and elderly) on 9/30/2024 and 10/6/2024. 3. Investigate an allegation of sexual abuse immediately and thoroughly as indicated in the facility ' s policy and procedure for Resident 1 ' s abuse allegation on 9/30/2024 and 10/6/2024. <p>These deficient practices resulted in the facility under reporting allegations of abuse, Resident 1 tried to elope on 9/30/2024. Resident 1 also felt unsafe from being touched at nighttime on 9/30/2024 and 10/6/2024. This deficient practice also had the potential to affect other vulnerable residents in the facility to experience possible abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 5/17/2017 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), Covid-19, and fibromyalgia (a disorder that causes pain and tenderness throughout the body, as well as fatigue and trouble sleeping).</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/21/2024, indicated Resident 1 ' s cognition (a term for the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) was moderately impaired, and needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) in eating, oral/personal hygiene, bathe self.</p> <p>During a review of Resident 1 ' s Change in Condition Evaluation, and Health Status Notes, dated 9/30/2024, indicated Resident 1 attempted to elope on 9/30/2024, at approximately 2 PM and Resident 1 stated, I want to leave, I feel unsafe because I believe men go into my room.</p> <p>During a review of Resident 1 ' s Program Counselor Note, dated 9/30/2024, indicated Resident stated that she tried to leave because she felt unsafe in the facility. She also stated that men or boys occasionally comes into her room to touch her. She also said that she knows this because she feels irritation on her private parts (breast and vagina) the next morning.</p> <p>During a review of Resident 1 ' s Change in Condition Evaluation, dated 10/7/2024, indicated on 10/7/2024 at 4:58 PM, two deputies came, stated that Resident 1 called the police to report someone walking to her room the previous night and touched her. Deputies interviewed Resident 1, LVN 1 and RNS 1. Based on the resident ' s diagnosis and interview, the deputies concluded that the story was not true.</p> <p>During a concurrent observation and interview on 10/9/2024 at 9:15 AM in Resident 1 ' s room, Resident 1 was lying in bed. Resident 1 stated she did not feel safe in the facility. Resident 1 stated, she felt like she was sexually abused because somebody touched her in her private area during the nighttime. Resident 1 stated, she could not remember when the incident happened, and stated, she reported it to Licensed Vocational Nurse 2.</p> <p>During an interview on 10/9/2024 at 11:10 AM with LVN2, LVN 2 stated, she was aware that Resident 1 reported being touched one day before Resident 1 called the police on 10/7/2024. LVN 2 stated, Resident 1 came to the Nursing Station and reported that she had irritation down there and stated somebody went into her room and touched her with dirty hands. LVN 2 stated, she brought Resident 1 to see Registered Nurse Supervisor (RNS) 1 for examination in the treatment room.</p> <p>During an interview on 10/9/2024 at 1:15 PM with the Administrator (ADM), the ADM stated, when a resident stated she was being touched during the night, the facility should take it seriously and start a thorough investigation right away to make sure the resident felt safe and protected. The ADM stated, per policy, the RN supervisor was responsible to start interviewing the resident, resident ' s roommate, staffs that were working during the shift, and report the alleged abuse within 2 hours to CDPH, Police and Ombudsman.</p> <p>During a concurrent record review and interview on 10/9/2024 at 1:55 PM with Program Counselor (PC) 1, Resident 1 ' s Program Counselor Note, dated 9/30/2024, was reviewed. PC 1 stated, he was doing a follow up visit with Resident 1 after Resident 1 attempted elopement on 9/30/2024. PC 1 stated, Resident 1 reported to him that she felt unsafe and being touched occasionally during the nighttime in her room. PC 1 stated, he reported to his Program Counselor Manager (PCM) 1 right after his visit session.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/9/2024 at 2:55 PM with RNS 1, RNS 1 stated, Resident 1 refused examination in her private part when she complained being touched by somebody on 10/6/2024. RNS 1 stated, Resident 1 had a history of reporting being touched in her private parts, could not provide information regarding the abuser ' s face, and refused examination so RNS 1 knew it was a false claim and did not report or start investigation. RNS 1 stated, Resident 1 called the police the next day. RNS 1 stated, she started the facility ' s investigation per protocol on 10/7/2024 after the police came. RNS 1 stated, the police officer came and told RNS 1 that based on the police ' s interview with Resident 1, the claim was not true. RNS 1 stated, she documented it in the facility ' s investigation and did not do her own. RNS 1 stated, normally, RNS 1 would start interviewing the resident ' s roommates, all staffs that were working during the shift and assign someone to be with the resident to make sure the resident was kept safe.</p> <p>During an interview on 10/9/2024 at 3:40 PM with Program Counselor Manager (PCM) 1, PCM 1 stated, she was aware that Resident 1 reported feeling unsafe and being touched on 9/30/2024 after Resident 1 attempted elopement. PCM 1 stated, she did not report it to her Administrator or the nursing staffs.</p> <p>During an interview on 10/9/2024 at 4 PM with the Director of Nurses (DON), the DON stated, any alleged abuse should be reported within 2 hours. The DON stated, on 9/30/2024 when Resident 1 reported being touched in the private parts and unsafe to PC 1, and on 10/6/2024 when Resident 1 reported being touched down there to LVN 1, PC 1 and LVN 1 should have reported the incidents right away so that they could start the investigation immediately. The DON stated, they could not assume that all alleged abuse was false before a thorough investigation.</p> <p>During a concurrent record review and interview on 10/9/2024 at 4:10 PM with the DON, Resident 1 ' s Investigation Form, dated 10/8/2024, was reviewed. The DON stated, there was no records of interviews from the staffs and resident ' s roommates documented. The DON stated, per facility ' s policy, the investigation for the abuse incident on 10/7/2024 was not thorough. The DON stated, if an alleged abuse was not reported, and the investigation was not thorough, the facility could not determine if the abuse was true, anything could happen to the resident and the facility would not be able to protect the resident and other residents in the facility from further abuse.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, indicated the following information:</p> <ul style="list-style-type: none"> - All reports of resident abuse are reported to local, state, and federal agencies and thoroughly investigated by facility management. - The individual conducting the investigation as a minimum that included: interviews the person reporting the incident; interviews any witnesses to the incident; interviews the resident; interviews staff members (on all shifts) who have had contact with the resident during the periods of the alleged incident; interviews the resident ' s roommate, family members, and visitors; documents the investigation completely and thoroughly. 		