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	10/17/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents was free from abuse, in accordance with the facility ' s policy and procedure(P&P) titled Management of Dangerous Behavior, and Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, in responding to manage Resident 1 ' s aggressive behavior when: 1. Program Counselor (PC) 10 grabbed Resident 1 from behind and take down the resident to the ground on 10/12/2024 between 8:55 am to 9 AM, due to a resident-to-resident altercation between Residents 1 and 2. 2. Resident 1 and PC 10, who was involved in a Resident to Staff abuse allegation, and Residents 1 and 2 ' s altercation, that happened on 10/12/24 between 8:55 am to 9 AM was not reported by facility staff, until Resident 1 notified Program Manager Counselor (PMC) 2 on 10/12/2024 at around 4:57 PM (7 hours). These deficient practices had the potential to injure Resident 1 and Resident 2, and the abuse to reoccur, which could negatively affect Resident 1 ' s and Resident 2 ' s quality of life. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included mood affective disorder (marked disruptions in emotions (severe lows called depression or highs called hypomania or mania), autistic disorder (harder for them to communicate and socialize with others), and mild intellectual disabilities (conditions that affect functioning in two areas: Cognitive functioning, such as learning, problem solving and judgement). A review of Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/26/2024, indicated Resident 1 ' s cognitive skills (ability to make daily decisions) was moderately impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating and personal hygiene, and independent with toileting, dressing and walking. (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: 05A109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, bipolar disorder (a brain disorder that causes extreme highs and lows in your moods), schizophrenia (a serious mental illness that affects a person's ability to think, feel, and behave normally), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Minimum Data Set (MDS - a federally mandated resident assessment tool), date 9/13/2024, indicated Resident 2 ' s cognitive skills (ability to make daily decisions) was moderately impaired. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with eating and personal hygiene, and independent with toileting, dressing and walking. During a review of Resident 1 ' s facility document titled Progress Notes, dated 10/12/2024, timed at 9:32 AM, indicated at 8:55 AM, Resident 1 became upset and aggressive during a group activity, after Resident 2 flipped him. The Progress Note indicated no physical contact was made and Resident 1 was counseled. No other nursing documentation entered about the incident until 10/13/2024. During a review of Resident 1 ' s facility document titled Progress Notes dated 10/13/2024 timed at 12:16 AM, the Progress Note indicated, on 10/12/24 at approximately 4:57 PM, Resident 1 approached PMC 2 and the RN supervisor and reported that during the morning shift, PC 10 questioned Resident 1 about the incident that happened earlier the same day around 8:55 AM between him and Resident 2. The Progress Note indicated that while in the office, PC 10 grabbed Resident 1 by the neck. The document further indicated after leaving the office, Resident 1 saw Resident 2 and became agitated and quickly punched Resident 2 to the face and back of the head. The Progress Note also indicated, Resident 1 felt PC 10 grabbed him from behind, picked him up and slammed him onto the floor. During a review of Resident 1 ' s Care Plan (CP) for behavior problem related to mood stabilization as manifested by calm and cooperative to verbal aggression, revised on 10/13/2024, indicated care plan interventions that included: a) be alert for mood instability, b) encourage using coping skills for mood issues, and be alert for mood instability, and prompt resident to attend groups to learn ways to cope with mood changes. During a concurrent observation and interview on 10/16/2024at 11:30 AM with Resident 1 in the hallway next to the Dining Room, Resident 1 was observed pacing back and forth. Resident 1 was observedwith a sitter, Certified Nurse Assistant (CNA) 2. Resident 1 stated, he remembered reporting an abuse incident and stated, Resident 2 was teasing him, so he hit Resident 2 (unable to recall where). Resident 1 stated the incident between Resident 1 and 2 happened on Saturday (10/12/2024) in the morning. Resident 1 stated, PC 10, spoke to him at the office and when he came out, he saw Resident 2, who gave him a finger sign so he hit him on the face. Resident 1 stated, PC 10 grabbed him from behind and slammed him to the Dining Room floor. During a concurrent observation and interview on 10/16/2024 at 11:45 AM with Resident 2, in the hallway next to the Dining Room. Resident 2 stated, the incident with Resident 1 happened on Saturday (10/12/2024) morning, Resident 1 hit him on the face, but he did not remember why. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 11:55 am, AM with PC 5, PC 5 stated, she worked on 10/12/2024. PC 5 stated, the incident with Resident 1 and PC 10 happened around 9 AM when Resident 1 and Resident 2 had an altercation at the courtyard, so PC 10 took Resident 1 to the office to be counseled. PC 5 stated, a few minutes after the incident, PC 5 heard a Code Yellow (code called for everyone to come and intervene to prevent dangerous behavior) in the Dining Room. PC 5 stated, when she came, she saw PC 10 holding Resident 1 from behind, then Resident 1 hit Resident 2 and tried to go after Resident 2. PC 5 stated that was the time when PC 10 put Resident 1 to the ground by himself. PC 5 stated the incidents happened around 9 AM, and she thought someone else will do the reporting. PC 5 stated, as per policy, any type of abuse should be reported within 2 hours. During an interview on 10/16/2024 at 1:30 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, he was the charge nurse in the afternoon shift on 10/12/2024. LVN 3 stated, the abuse incident between Resident 1 and 2, and PC 10 was not reported immediately or within 2 hours. LVN 3 stated Resident 1 reported the alleged abuse to Program Counselor [PMC] 2 just before 5 PM, that day [10/12/24], even though the alleged abuse happened around 9 AM. LVN 3 stated, he did not know why alleged abuse was not reported right away. LVN 3 stated that any type of abuse should be reported within 2 hours according to the facility ' s P&P. During an interview on 10/16/2024 at 2:45 PM, with CNA 3, CNA 3 stated she was sitting next to Resident 2, but she was watching another resident in the Dining Room. CNA 3 stated, she witnessed Resident 1 came and hit Resident 2 on the face, then saw PC 10 grabbed Resident 1 and put him to the ground and held Resident 1 down momentarily. CNA 3 stated, she did not report the incident, because she thought someone else would report the alleged abuse. During an interview on 10/16/2024 at 2:55 PM with the Administrator (ADM), the ADM stated, what PC 10 did to Resident 1 was considered abuse, because he grabbed Resident 1 and dropped the resident to the ground. The ADM stated what PC 10 had done to Resident 1was not in accordance with the facility ' s P&P, to restrain an aggressive resident. The ADM stated, the facility ' s P&P required at least 2 people to contain an aggressive resident to prevent injury to the resident. The ADM stated, following the facility ' s P&Pwas to ensure the safety of the residents and staff. The ADM stated, the incident was not reported timely, and the altercation between Resident 1 and Resident 2 was not reported timely as well. The ADM stated, both incidents happen around 9 AM and was not reported to PMC 2 until 4:57 PM on 10/12/24 by Resident 1. The ADM stated, the facility does not have any documentation of the incidents prior to the report at 4:57 PM. During an interview on 10/16/2024 at 3:35 PM with PMC 2, PMC 2 stated, that the facility's P&P for managing an aggressive resident would be to haveat least 2 people to go between the resident/s, build a human wall, but should not grab a resident from behind and throw the resident to the ground. The PMC 2 stated it was considered abuse. PMC 2 stated the facility ' s P&P should be followed to prevent injury to the resident and staff. During an interview on 10/17/2024 at 8:05 AM with Program Director (PD) 1, PD 1 stated, program directors oversee program managers, program counselors, and mental health workers. PD 1 stated, that according to the facility ' s P&P, there needs to be at least 2 people to be present when managing an aggressive resident, to deescalate the situation. PD 1 stated, the staff should counsel or create a human barrier between residents who are having an altercation. PD 1 stated, there is no reason for a program counselor to grab a resident and take the resident down to the ground because it would be considered abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 2:10 PM with the ADM, ADM stated, PC 10 did not follow the facility ' s P&P on Abuse and Management of Dangerous Behavior, when PC 10 threw Resident 1 to the ground on 10/12/2024. The ADM stated the altercation between Resident 1 and Resident 2 thathappened at the same time should have been reported immediately as well. The ADM stated both incidents could have caused injury and reoccurrence. During a review of the facility ' s policy and procedure (P&P) titled Management of Dangerous Behavior, dated 10/1/2024, indicated; a) the goal of all interventions is to prevent further escalation and ensure a safe environment for the patient involved and other patients, b) the use of systematic and planned intervention strategies minimizes the risk of injury to both patients and staff, c) restraints has the potential to produce serious consequences both physically and psychologically, and therefore should be only used physically and psychologically, therefore should only be used only when necessary, d) Physical restraint means use of manual hold to restrict freedom of movement of all part of a persons body for purpose of behavioral restraint, it may involve stabilizing a patient against the wall, on the floor or where they stand, and restrain only as a team, single person restraints should be avoided, problems with one on one restraints includes inflicting injury by misjudging to hold safely. A review of the facility ' s policy and procedure (P&P) titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program revised 4/2021, indicated; a) Residents have the right to be free from abuse or neglect, this include but not limited to physical abuse, b) protect residents from abuse by anyone including but necessarily limited to facility staff and other residents. A review of the facility ' s policy and procedure (P&P) titled Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating revised 9/2022,indicated: a) All reports of resident abuse, neglect are reported to local, state and local agencies (as required by current regulations) and thoroughly investigated by facility management, b) If Resident abuse, neglect is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law, c) the administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies which includes; the state and licensing/ certification agency, the local/state ombudsman, and law enforcement officials, and d) immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203 Based on observation, interview, and record review, the facility failed to prevent further abuse, and mistreatment from occurring by ensuring Resident 5 with known hypersexual behavior (a psychological and behavioral condition where a person has intense, repetitive sexual urges or fantasies that they can't control. These behaviors can be harmful to a person's health, relationships, career, and other aspects of their life) was monitored to prevent inappropriate touching of one of three sampled residents (Resident 4) whom Resident 5 touched on the buttocks on 10/15/2024 and 10/17/2024 without the resident's consent. This failure resulted in Resident 4 verbalized feeling frustrated and not feeling safe in her environment when Resident 5 was around which could negatively affect the psychosocial (mental and emotional being) of Resident 4. In Resident 5 was also at risk for altercation that could result in accident and injuries. Findings. During a review of Resident 4's Admission Records (Face sheet) indicated the facility admitted Resident 4 on 5/17/2017 with a diagnosis that included paranoid schizophrenia (a mental illness characterized by paranoia [fear and distrust of others], delusions [misconceptions or beliefs that were firmly held, contrary to reality], and hallucinations [a false perception of objects or events that involved sight, touch, taste, sound, and smell). During a review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/21/2024, the MDS indicated Resident 4's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was moderately impaired and resident had delusions. During a review of Resident 4's Care Plan (CP), dated 10/15/2024, Resident 4 was a victim of sexually inappropriate behavior due to Resident 5 touching Resident 4's buttocks. The care plan goal was to keep Resident 4 safe. The intervention included to monitor Resident 4 every 15 minutes. During a review of Resident 5's Admission Records, the facility admitted Resident 5 on 12/24/2019 and readmitted Resident 5 on 2/27/2024 with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and paranoid schizophrenia. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognition was severely impaired and resident had delusions. During a review of Resident 5's CP, revised on 4/3/2024, indicated Resident 5 had a wandering (going to places aimlessly) tendency with inappropriately touching female staff with interventions that included to redirect Resident 5 when he is exhibiting sexually inappropriate behavior towards staff or other residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5's CP, dated 5/6/2024, Resident 5 had entered Resident 4's room and squeezed Resident 4's buttocks without her permission. the intervention included to place resident on Line of Sight (LOS, a resident was always within the view of the assigned staff member) for exhibiting sexually inappropriate behavior towards staff or other residents. During a review of Resident 5's Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), indicated on 5/8/2024 Resident 5 started receiving Casodex (Bicalutamide, a medication to treat prostate cancer with a side affect to decrease a male-presenting person's sex drive) 50 milligrams (mg, a metric unit of measure, used for medication dosage and/or amount) by mouth one time a day for hypersexual behavior. During a review of the Order Summary Report starting 6/17/2024, indicated to monitor Resident 5 every 15 minutes of every shift for safety. During a review of Resident 5's CP, revised on 4/3/2024 added an intervention on 6/17/2024 to monitor Resident 5 every 15 minutes. During a review of Resident 5's CP, revised on 10/15/2024, indicated Resident 5 had socially inappropriate behavior that was manifested by inappropriately touching female staff. The CP indicated Resident 5 inappropriately touched staff members on 3/21/2024, 3/24/2024, 4/10/2024, 4/12/2024, 5/7/2024, and 5/10/2024. The CP indicated Resident 5 inappropriately touched Resident 4 on 5/6/2024 and 10/15/2024. The CP's interventions included monitoring Resident 5 every 15 minutes, and redirect Resident 5 to avoid touching other residents and staff members. During a review of Resident 5's CP, dated 10/15/2024, Resident 5 had displayed sexually inappropriate behavior by touching Resident 4's buttocks. The CP intervention was to continue every 15 minutes monitoring for safety. During an observation and interview on 10/16/2024 at 11:51 AM with Resident 4 in the facility's library room, Resident 4 appeared frustrated when she demonstrated how Resident 5 hit her buttocks with an open palm. Resident 4 stated, yesterday (10/15/2024) she was standing in line when she felt Resident 5 touch her buttocks area and walked away. Resident 4 stated, she believed Resident 5 walked into the girl's rooms and tried to find which girl he wants to mess with. Resident 4 stated, she yelled at Resident 5 to get out and do not be in the girl's room. During an interview on 10/16/2024 at 12PM with Program Counselor (PC) 1, PC 1 stated it happened on 10/15/2024 at the breakfast line around 8AM or 8:10 AM. PC 1 stated, on 10/15/2024, Resident 4 told PC 1 that Resident 5 touched her butt and walked away. PC 1 stated, the first incident happened a few months ago where Resident 5 went into Resident 4's room and touched her buttocks then. PC 1 stated, Resident 4 appeared to be more reserved and hesitant to share her thoughts with PC 1 compared to before the first incident. During an interview on 10/16/2024 at 12:25 PM with PC 2, PC 2 stated, Resident 5 had wandering behavior in the last two months and was unable to stay still. PC 2 stated, Resident 5's behavior included pacing around the facility, looking through the trash cans, moving different items around, and wandering into other resident's room. PC 2 stated, Resident 5 was less coherent by putting words together in a sentence that was not understandable. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 1:06PM with Mental Health Worker (MHW) 1, MHW 1 stated he was monitoring the dining room hallway around breakfast time and saw Resident 4 lined up in the breakfast line when Resident 5 came up and tapped Resident 4's butt. MHW 1 stated, Resident 4 appeared shocked and asked, why did (Resident 5) touch me? During a concurrent record review and interview on 10/16/2024 at 2:59 PM with Licensed Vocational Nurse (LVN) 2, Resident 5's CP about inappropriate sexual behavior, Order Summary Set, and October 2024 Medication Administration Record (MAR) was reviewed. LVN 2 stated, Resident 5 needed to be Line of Sight to redirect Resident 5's hypersexual behavior immediately to prevent another incident between Resident 4 and Resident 5, and to provide safety to other residents. LVN 2 stated, there was no documented evidence in Resident 5's clinical records that Resident 5 was monitored for hypersexual behavior. LVN 2 stated, there should be monitoring for Resident 5's sexual behavior. During a concurrent record review and interview on 10/16/2024 at 3:36PM with LVN 1, Resident 5's Order Summary, Change of Condition Evaluation dated 10/15/2024, and October 2024 MAR was reviewed. LVN 1 stated, on 10/15/2024 Resident 5 walked by Resident 4, who was standing in line, and touched her butt with an open palm. LVN 1 stated, the medical physician's (Physician 1) decided to start Resident 5 on Casodex to lower Resident 5's hypersexual behavior. LVN 1 stated, she notified Physician 1 and the Psychiatrist (Physician 2) on 10/15/2024 after Resident 5 touched Resident 4's buttocks, LVN 1 stated, Resident 5's hypersexual behavior should have been monitored since May 2024 as ordered by the physician. During an observation and interview on 10/17/2024 at 11:46 AM with Resident 4 in the facility's library, Resident 4 made pushing motion with her hands when talking about her interaction with Resident 5 during morning medication pass. Resident 4 stated, Resident 5 pulled her hair, so she reacted by shoving Resident 5. Resident 4 stated, it made me not feel safe here because of what happened with Resident 5. Resident 4 stated, I feel like I have to curse at him (Resident 5) when she saw Resident 5 in the hallway. During an observation on 10/17/2024 at 12:05 PM in Resident 5's room, a staff member was sitting in the doorway monitoring Resident 5 lying in bed. During an interview on 10/17/2024 at 2:30PM with MHW 2, MHW 2 stated, on 10/15/2024, he observed Resident 4 was standing in line by Nursing Station 2 waiting to get medication when Resident 5 walked behind Resident 4 and attempted to touch Resident 4's hair. MHW 2 stated, she was able to redirect Resident 5 before Resident 5 touched Resident 4's hair, and Resident 5 walked away. MHW 2 stated, Resident 5 walked back in the hallway but towards Resident 4 when Resident 4 punched (Resident 5) in the stomach. MHW 2 stated, Resident 4 said I am tired of (Resident 5) touching me. It has been twice here (Resident 4 pointed to her butt) and now (Resident 5) tried to touch here (Resident 4 brushed her hair with her hand). During an interview on 10/17/2024 at 2:43PM with PC 4, PC 4 stated, when he interviewed Resident 5 about touching Resident 4, Resident 5 said, I can do whatever I want. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 3:21PM with LVN 1, LVN 1 stated, sexual abuse was defined as any physical touch unwanted by the other person. LVN 1 stated, what Resident 5 did to Resident 4 can be considered sexual abuse especially because Resident 4 did not want to be touched. LVN 1 stated, Resident 4 was already paranoid of people, and the incident would add to her paranoia and make her feel even more uncomfortable around people. LVN 1 stated, Resident 5 should have been closely supervised so Resident 4 and Resident 5 do not see each other. During a review of the facility's policies and procedures (P&P), titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021,the P&P indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The P&P indicated the facility has a commitment to protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including other residents.