

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 10/29/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48661</p> <p>Based on interview and record review the facility failed to notify the resident ' s physician for one of two sampled residents(Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1. Notify Resident 1 ' s physician when Resident 1 continued to be non-compliant with scheduled medications [Zyprexa and Valproic acid] for a consecutive five (5) to 12 days. 2. Implement the facility ' s policy & procedure (P&P) titled Change in a Resident ' s Condition or Status by not notifying the physician when the resident refused medication two (2) or more consecutive times. <p>This deficient practice had the potential for the resident not to receive the necessary interventions to prevent further non-compliance of medications and negatively affect the provision of necessary care and services.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 3/11/2024, with diagnoses including schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior), insomnia (trouble falling asleep or staying asleep), and extrapyramidal and movement disorder (a group of movement dysfunctions that could be caused by taking dopamine antagonists, often antipsychotic drugs).</p> <p>A review of Resident 1 ' s History & Physical (H&P) dated 3/11/2024, indicated the resident was positive for mental illness.</p> <p>A review of Resident 1 ' s Order Summary Report dated 7/18/2024, indicated the Physician ordered Zyprexa (Olanzapine - an antipsychotic medication that could treat several mental health conditions like schizophrenia and bipolar disorder) oral tablet, give five (5) milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth two (2) times a day for paranoid delusions (fixed beliefs that someone was being persecuted or harassed, even when there was no evidence to support these beliefs) manifested by (m/b) inability to process internal stimuli causing anger.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/31/2024, indicated the resident had moderate cognitive impairment (could not navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated the resident was taking antipsychotic medications and the indication for why the resident was taking antipsychotic medications were noted. The MDS indicated the resident received antipsychotics on a routine basis and Physician documented a Gradual Dose Reduction (GDR) was clinically contraindicated on 6/13/2024.</p> <p>A review of Resident 1 ' s Psychiatric Progress Note dated 8/15/2024, indicated the resident had a past history of medication non-compliance and did not have insight regarding his mental condition. The Progress Note indicated the resident ' s overall psychiatric condition was declining. The Progress Note indicated the Physician did not recommend lower level of care due to the resident ' s impaired insight and judgement.</p> <p>A review of Resident 1 ' s Medication Administrator Record (MAR) dated 10/1/2024 to 10/28/2024, indicated the resident refused the 9 AM Zyprexa dose 20 times with a consecutive refusal of 12 days from 10/7/2024 to 10/18/2024. The MAR indicated the resident refused the 9 PM Zyprexa dose 16 times with a consecutive refusal of 11 days from 10/1/2024 to 10/11/2024.</p> <p>A review of Resident 1 ' s Order Summary Report dated 10/11/2024, indicated the Physician ordered Valproic Acid (used to reduce or prevent manic episodes) oral solution 250 mg/5 milliliters (ml - metric unit used to measure capacity that was equal to one-thousandth of a liter). Give 30 ml by mouth at bedtime for mood stabilization (the process of using medication or other methods to help control and even out mood swings) m/b going from calm and cooperative to extreme verbal agitation and physical aggression.</p> <p>A review of Resident 1 ' s MAR dated 10/11/2024 to 10/27/24, indicated the resident refused the 9 PM Valproic Acid dose six (6) times with a consecutive refusal of five (5) times from 10/13/2024 to 10/17/2024.</p> <p>A review of Resident 1 ' s Change of Condition (COC) dated 10/18/2024 at 3:25 PM, indicated the resident hit a male peer on the back. The COC indicated the resident ' s representative, and the Physician were notified with new orders for Zyprexa five (5) mg IM, PRN for every oral refusal times 14 days.</p> <p>A review of Resident 1 ' s Non-Compliance Care Plan dated 10/22/2024, indicated the resident had been refusing medications for several days. The Care Plan goal indicated for the resident to be compliant with physician ' s orders at all times. The Care Plan Interventions included for the resident to learn effective habits, give positive reinforcement for compliant behavior, and identify influencing factors associated with non-compliant behavior. The Care Plan did not indicate interventions to contact the physician for non-compliance.</p> <p>A review of Resident 1 ' s Progress Notes dated 10/2/2024 to 10/28/2024, indicated there were no notes indicating the physician was notified for Resident 1's medication non-compliance.</p> <p>During an interview on 10/28/2024 at 2:25 PM, Resident 1 stated he hit a male peer on the back because I was told by a voice in my head that he was a murderer and to him on the back of his head. The resident stated the voice he heard told him to be physical.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/29/2024 at 10:39 AM, Licensed Vocational Nurse (LVN) 1 stated the resident sometimes struggles with medication compliance. LVN 1 stated yesterday the resident took the medication late and this morning the resident refused. LVN 1 stated she encourages the resident to take the medication but if after three (3) days the resident continued to refuse, LVN 1 would ask the facility Counselor to intervene.</p> <p>During an interview on 10/29/2024 at 11:01 AM, the LVN Supervisor (LVNS) stated Resident 1 should have had more monitoring because the resident was non-compliant with medications. The LVNS stated when a resident was non-compliant with medications for three (3) days, the facility staff must call the physician to obtain new orders.</p> <p>During an interview on 10/29/2024 at 11:44 AM, the Director of Nursing (DON) stated when residents were not compliant with medications, the facility staff must notify the physician and continue monitoring the resident. The DON stated if the resident continued to be non-compliant, the facility staff must continue to notify the physician. The DON stated because Resident 1 was not compliant with his medication, the resident should have been on every 15-minute monitoring for safety. The DON stated if the resident was not being monitored, other residents could be at risk for being hit.</p> <p>During an interview on 10/29/2024 at 2:30 PM, the LVNS stated after reviewing the resident ' s records for the month of October, she could not find any notifications to the physician regarding the resident ' s refusal of medications. The LVNS stated she along with the physician should have been notified for more follow up.</p> <p>During a concurrent interview and record review of the Change of Condition Policy & Procedure on 10/29/2024 at 2:34 PM, the Administrator (ADM) stated the physician should have been notified two (2) days after the non-compliance of medication. The ADM stated there should have been documentation to the physician regarding the refusal of medications to get new orders or recommendations on what to do next. The ADM stated if the physician was not notified, the resident would continue to be non-compliant with medications and the resident would not be closely monitored. The ADM stated if the resident was not closely monitored, that could result in aggressive behavior.</p> <p>A review of the facility ' s P&P titled Change in a Resident ' s Condition or Status revised 2/2021, indicated The nurse would notify the resident ' s attending physician or physician on call when there had been a refusal of treatment or medications two (2) or more consecutive times.</p>		