

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  11/13/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was specific for one of three sampled residents (Resident 5) who had physical aggression toward another resident on 11/7/2024.</p> <p>This failure had a potential to result in Resident 5 ' s inadequate and incomplete provision of care.</p> <p>Findings:</p> <p>During a review of Resident 5 ' s Admission Record, indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bipolar type schizoaffective disorder [a rare mental health condition that combines symptoms of schizophrenia (a mental illness that can affect thoughts, mood and behavior) and bipolar disorder (a serious mental illness that causes extreme shifts in mood, energy, and activity levels), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly)], bipolar disorder, and mild intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently).</p> <p>During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 9/26/2024, indicated Resident 5 ' s cognition (ability to think, remember, and reason with no difficulty) was moderately impaired, and was able to independently walk at least 150 feet in a corridor or similar space.</p> <p>During a review of Resident 5 ' s Care plan, revised on 11/8/2024 indicated Resident 5 had paranoid delusion manifested by inability to process internal stimuli causing anger/extreme paranoid thoughts and auditory hallucinations manifested by responding to internal stimuli. The care plan indicated on 11/7/2024 Resident 5 had physical aggression toward peer due to hearing voices. The care plan did not specify what Resident 5 was hearing that caused him to be physically aggressive toward peer.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024 at 4 PM with Licensed Vocational Nurse 2, LVN 2 stated, there was a care plan that addressed Resident 5 ' s incident where he hit another resident because Resident 5 was hearing voices. LVN 2 stated, the care plan should be specific to what Resident 5 was hearing that caused him to hit another resident so that the facility ' s staff would be aware and prevent the next incident to happen. LVN 2 stated, by reading the Resident 5 ' s care plan, he would not know the root cause. LVN 2 stated, the care plan was important because it was guidance for the care team to know how to take care of the resident.</p> <p>During a concurrent record review and interview on 11/14/2024 at 12:40 PM with Registered Nurse (RN) 1, Resident 5 ' s care plan was reviewed. RN 1 stated, Resident 5 ' s care plan should be more specific to what Resident 5 was hearing when he hit another resident. RN 1 stated, it was very important to know what the voices told Resident 5 to do because it could be a dangerous demand that the facility ' s staff need to be aware to effectively monitor and protect other residents.</p> <p>During an interview on 11/14/2024 at 7:15 PM with the Administrator (ADM), the ADM stated, the care plan needed to be comprehensive, person-centered, specific to each resident. The ADM stated, hearing voices was not enough, it should indicate what Resident 5 was hearing so the facility ' s staffs would be aware and provide Resident 5 with proper care.</p> <p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, revised March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. When possible, interventions address the underlying sources of the problem areas not just symptoms or triggers.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50203</p> <p>Based on observation, interview, and record review, the facility failed to provide one of three sampled residents (Resident 8) with adequate supervision to prevent accidents when Resident 9 inappropriately touched Resident 8 in the dining room hallway.</p> <p>The failure resulted in Resident 8 verbalizing feeling targeted by Resident 9 and not feeling safe within her environment.</p> <p>Findings</p> <p>During a review of Resident 8 ' s Admission Record, the facility admitted Resident 8 on 3/22/2023 with diagnoses that included paranoid schizophrenia (a mental illness characterized by paranoia [fear and distrust of others]), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety (a person has excessive worry and feelings of fear, dread, and uneasiness).</p> <p>During a review of Resident 8 ' s Order Summary Report (instructions that communicated the medical care that the resident received while in the facility), indicated an order date of 3/22/2023, the order summary report indicated Resident 8 was placed on every 15-minute monitoring (a certified nurse, program counselor, or mental health worker monitors and documents a Resident ' s location every 15 minutes) for safety.</p> <p>During a review of Resident 8 ' s Minimum Data Set (MDS, a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 8 cognition (a person's mental process of thinking, learning, remembering, and using judgement) was moderately impaired and had delusions (misconceptions or beliefs that were firmly held, contrary to reality).</p> <p>During a review of Resident 8 ' s care plan, dated 11/10/2024, the care plan indicated Resident 8 was a victim of inappropriate sexual behavior with a goal for Resident 8 to feel safe by the target date of 11/13/2024. The care plan ' s interventions included monitoring Resident 8 every 15 minutes and provide Resident 8 with individual therapy.</p> <p>During a review of Resident 9 ' s Admission Record, the facility admitted Resident 9 on 7/31/2007 and readmitted Resident 9 on 8/16/2022 with diagnoses that included schizoaffective disorder (a mental disorder characterized by symptoms of both schizophrenia (psychosis) and a mood disorder) and major depressive disorder (a mental health condition that causes persistently low or depressed mood and loss of interest).</p> <p>During a review of Resident 9 ' s Order Summary Set, indicated an order date of 7/5/2022, Resident 9 was placed on every 15-minute monitoring for safety during the 7AM to 3PM shift and the 3PM to 11PM shift. The order summary set report indicated Resident 9 was placed on Line Of Sight (LOS, a resident was always within the view of the assigned staff member) to monitor for safety on the 11PM to 7AM shift.</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 a review of Resident 9 ' s Order Summary set, indicated an order date of 7/72023, the order summary set report indicated Resident 9 was placed in the first group scheduled to eat at 7:30AM in the dining room during every mealtime.</p> <p>During a review of Resident 9 ' s MDS, dated [DATE], the MDS indicated Resident 9 was moderately cognitively impaired and had delusions.</p> <p>During a review of Resident 9 ' s care plan, revised on 11/10/2024, indicated Resident 9 had a history of socially inappropriate behavior. The care plan indicated on 4/5/2024, Resident 9 had smacked a female resident ' s (unable to identify) buttocks. The care plan indicated on 11/10/2024, Resident 8 had put both his hands on [Resident 8 ' s] hips and thrust, making physical contact. The care plan ' s goal indicated Resident 9 will have no episodes of touching female ' s peer or others at any time by 11/13/2024. The care plan ' s interventions included placing Resident on every 15-minute monitoring, explaining to Resident 9 to keep his hands to himself and respect other female peer ' s boundaries, and to counsel Resident 9 for inappropriate behavior.</p> <p>During a review of Resident 9 ' s care plan, date initiated 11/10/2024, indicated Resident 9 had sexually inappropriate behavior by putting his hands on [Resident 8 ' s] hips and thrust (pushed with force), making physical contact. The care plan ' s interventions included to continue every 15-minute monitor for safety during the 7AM - 3PM shift and the 3PM - 11PM shift, to continue LOS during the 11PM - 7AM shift, and to provide one to one counseling.</p> <p>During a review of facility ' s document titled STP (Special Treatment Program) Program Schedule, dated 11/10/2024, this document indicated breakfast was from 7:30AM to 9:00AM with the dining room door monitored by Activities.</p> <p>During a review of the facility ' s document titled Observation Record, dated 11/10/2024, Resident 9 was in the hallway at 7:30AM.</p> <p>During a concurrent observation and interview on 11/13/2024 at 11:04AM with Resident 8 in the conference room, Resident 8 placed her hands on her hips when she described Resident 9 ' s actions. Resident 8 stated, Resident 9 was in front of the door, and Resident 8 asked Resident 9 if she could look in the kitchen window. Resident 8 stated, Resident 9 moved aside and suddenly stood behind her, grabbed her hips, and started to thrust himself. I felt everything. Resident 8 stated, she pushed him off her and said that ' s not right. You should not do that. Resident 8 stated, Resident 9 told her Well you are a girl and right in front of me. Resident 8 stated, she does not feel safe because I feel like I am a target.</p> <p>During an interview on 11/13/2024 at 11:16AM with Program Counselor (PC) 6, PC 1 stated, Resident 8 told PC 6 that Resident 9 came behind her and thrust into her. PC 1 stated, it happened on 11/10/2024 around breakfast time at 7:30AM. PC 6 stated, Resident 8 was looking into cafeteria through the little window in the dining room door. PC 6 stated, one person was assigned to monitor the front of the line at the dining room door and another person was assigned to monitor the back of the line. PC 6 stated, the persons assigned to monitor the line go to their assignments around 7:30AM before breakfast starts.</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 observation and interview on 11/13/2024 at 11:29AM with Resident 9 in the patio area, Resident 9 was sitting down in the chair with his arms and legs crossed. Resident 9 stated, [Resident 8] was looking into the window, and I got close to her. Resident 9 stated, he did not touch her hips.</p> <p>During an interview on 11/13/2024 at 11:35AM with PC 7, PC 7 stated, Resident 9 has a history of inappropriately touching. PC 2 stated, Resident 9 was aware he cannot be around females.</p> <p>During an interview on 11/13/2024 at 11:56AM with Mental Health Worker (MHW) 1, MHW 1 stated, at 7:28AM she was monitoring Station 2 hallway when she heard someone yell get off her. MHW 1 stated, she walked to the dining room hallway, and Resident 8 told her Resident 9 went behind her, put both hands on her (Resident 8 ' s) hips, and thrust on her, making full contact with thighs and private parts. MHW 1 stated, the activities aides help monitor the dining room lines during the weekend. MHW 1 stated, there was no staff member posted in the dining room hallway monitoring the dining line when Resident 9 inappropriately touched Resident 8.</p> <p>During an interview on 11/13/2024 at 2:00PM with the Activity Director (AD), the AD stated the activities aides assist with monitoring the dining room line for breakfast and lunch on Saturdays and Sundays. The AD stated, the staff discouraged residents from lining up before 7:30AM because no staff can be present in the dining room hallway as staff have other duties.</p> <p>During an interview on 11/13/2024 at 3:52PM with Resident 2 in Resident 2 ' s room, Resident 2 stated, Resident 8 was looking through the small window in the dining room door when Resident 9 came behind her and thrust into Resident 8. Resident 2 stated, he did not remember seeing staff members in the hallway.</p> <p>During an interview on 11/13/2024 at 4:00PM with the Administrator (ADM), the ADM stated, all activities aids were Pro-ACT (Professional Assault Crisis Training, a training program for professional who work with individuals whose disabilities may manifest in dangerous behavior) trained and were trained to de-escalate and re-direct a conflict between residents. The ADM stated the activities aides were also trained to call a Code Yellow (staff is alerted to provide assistance in response of a resident ' s escalating behavior) for extra help. The ADM stated, there should be one activity aide posted at the front of the dining room line by the dining room door and one activity aide posted at the end of the dining room line. The ADM stated, there was supposed to be a MHW monitoring the hallways, but there were so many other residents that she did not see it (Resident 8 and Resident 9), but she heard it.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, the P&amp;P indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P&amp;P indicated the facility has a commitment to protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including other residents.</p> <p>During a review of the facility ' s P&amp;P, titled Supervision and Precautions, dated 10/2024, the P&amp;P indicated staff will provide daily supervision with the needs of all the patients hourly, and the hallway monitor Station 1 and 2 on all shifts. The P&amp;P indicated the patient will be assigned to nursing or program staff for a precaution, including every 15-minute checks, to view the patient is safe.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</b></p> <p>Based on observation, interview, and record review, the facility failed to address, obtain necessary behavioral health care needs, develop and implement person centered care plans for the behavioral healthcare needs for one of seven sampled residents (Resident 7) with socially inappropriate behavior manifested by sexually inappropriate touching among female staff and peer. In addition, the facility failed to monitor the resident for the specific sexually inappropriate behavior problem manifested by the resident, and not just inappropriate behaviors in general.</p> <p>This deficient practice had the potential for other female residents without the capacity to consent to sexual activities to experience unwanted non-consensual sexual contact from Resident 7.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record [AR], the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, major depressive disorder, and bipolar type schizoaffective disorder.</p> <p>During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 6/12/2024, the MDS indicated Resident 3 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired, and was able to independently walk at least 150 feet in a corridor or similar space.</p> <p>During a review of Resident 3 ' s Care plan, the care plan indicated on 12/10/2021, Resident 3 had a care plan to focus on Resident 3 ' s inability to comprehend/understand the assessment for capacity to consent or withhold sexual advances. The care plan indicated Resident 3 did not have capacity to consent to sex. The care plan goals indicated the resident would not be sexually abused by anyone and ensure resident safety. The interventions included to provide q15 minutes (q15 ' ) monitoring for safety and provide oversight supervision every shift.</p> <p>During a review of Resident 3 ' s Change of Condition (COC), dated 11/13/2024, the COC indicated on 11/13/2024 Resident 3 was inappropriately touched by Resident 7.</p> <p>During a review of Resident 7 ' s Admission Record [AR], the AR indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included bipolar type schizoaffective disorder, tachycardia, and hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 7 ' s care plan, the care plan indicated Resident 7 had a care plan since 9/24/2022 for socially inappropriate behavior manifested by sexually inappropriate touch toward female staff. The care plan goal was that the resident would not exhibit any socially inappropriate behavior such as touching or licking anyone. Resident 7 ' s care plan issues listed Resident 7 ' s incidents on 4/10/2024, for licking a female peer ' s ear, on 10/23/2024 for groping a female peer ' s right breast, on 11/7/2024 for attempting to touch a female program manager ' s buttock, and on 11/13/2024 for inappropriately touching a female peer. The care plan interventions that were added on 4/12/2024 included to provide Resident 7 with 1:1 counseling and to advise the resident to stay away from female peers in order to prevent any incident from happening. The care plan indicated interventions were not reviewed and revised for the incident that happened on 11/7/2024 [for attempting to touch a female program manager ' s buttock].</p> <p>During a review of Resident 7 ' s physician orders, dated 1/17/2024, the order indicated the physician ordered Resident 7 to be placed on q15 ' monitoring due to history of inappropriate behavior.</p> <p>During a review of Resident 7 ' s COC, dated 4/10/2024, the COC indicated Resident 7 licked a female resident ' s ear for no reason and ran away and staff continued to monitor Resident 7 every 15 minutes for safety.</p> <p>During a review of Resident 7 ' s IDT Review, dated 4/14/2024, indicated IDT recommendations included q15 ' monitoring and Resident 7 was counseled not to lick peer.</p> <p>During a review of Resident 7 ' s Post-Event Review, dated 10/23/2024, the Review indicated on 10/23/2024 at 9 PM, Resident 7 was seen approaching a female resident while she was drinking water at the water fountain Station 2 and grope her right breast. The record indicated; the IDT met with Resident 7 to discuss the resident ' s alleged sexual abuse towards female peer. The IDT recommended 1:1 counseling and indicated the care plan updated as needed in the areas of behavior monitoring and supervision.</p> <p>During a review of Resident 7 ' s Psychiatric progress Note, dated 10/24/2024, indicated Resident 7 touched a peer ' s breast a couple of days ago. The record indicated, Resident 7 had had issues attempting to touch others and had impaired insight/judgement.</p> <p>During a review of Resident 7's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/5/2024, indicated Resident 7 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired, and was able to independently walk at least 150 feet in a corridor or similar space.</p> <p>During a review of the facility ' s Station 1 &amp; 2 Q15 ' /LOS list, dated 11/7/2024, the list indicated Resident 7 was placed on q15 ' monitoring due to elopement risk and socially inappropriate behavior since 1/18/2024.</p> <p>During a review of Resident 7 ' s Program Counselor Note, dated 11/7/2024, the Note indicated Resident 7 attempted to touch a female program manager ' s buttock. The program manager called his attention, but he continued to try to touch her. The resident held onto the door not allowing the Program manager to close it until a CNA (unspecified) came to redirect him.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ABC Investigation Form, dated 11/13/2024, the Form indicated on 11/13/2024 at around 1:15 PM, Resident 3 was sitting on the bench while waiting for medications in Nursing Station 1 when Resident 7 walked by. The record indicated, Resident 7 bent over Resident 3 and was observed by the Director of Staff Development (DSD) that Resident 7 was touching Resident 3 ' s groin area over her clothes. The DSD asked both residents to stop and Resident 7 walked away.</p> <p>During a review of Resident 7 ' s Observation Record, dated from 11/5/2024 to 11/13/2024, indicated Resident 7 was on q15 ' monitoring.</p> <p>During a concurrent interview and observation on 11/13/2024 at 3 PM with Resident 7 in Resident 7 ' s room, Resident 7 was observed sitting at the bedside. Resident 7 confirmed he touched Resident 3 and pointed to his left inner thigh when asked where he touched Resident 3.</p> <p>During an interview on 11/13/2024 at 3:15 PM with the PC 3, PC 3 stated, Resident 7 was well known for inappropriate touching the females including residents and staffs. PC 3 stated, the female staffs were all aware of Resident 7 ' s behavior and would be very cautious and avoid walking by Resident 7. PC 3 stated, the female staffs would try to avoid the resident ' s hands because Resident 7 would not keep his hands to himself.</p> <p>During an interview on 11/13/2024 at 3:35 PM with CNA 1, CNA 1 stated she was familiar with Resident 7, but she was not his regular CNA. CNA 1 stated, she saw him often walking around the facility in the hallway and he liked to hug other female residents a lot. CNA 1 stated, she did not think it would be inappropriate enough to report his hugging other female residents. CNA 1 stated, she was not aware if he had any sexual inappropriate behavior toward female residents or staffs before.</p> <p>During an interview on 11/13/2024 at 3:45 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 7 would frequently stick his hands out and tried to touch other people. LVN 1 stated, once in a while she saw Resident 7 try to stick his hands out. LVN 1 stated, Resident 7 stuck his hands out and tried to touch her hand when she gave him his medications a while ago.</p> <p>During an interview on 11/14/2024 at 1:40 PM with Registered Nurse (RN) 1, RN 1 stated, when a CNA was assigned to monitor Resident 7 every 15 minutes, the CNA did not need to know what specific behavior Resident 7 should be monitored for. RN 1 stated, when the CNA check Resident 7 every 15 minutes, the CNA needed to check where the resident was, and what the resident was doing if it was normal or abnormal to document it in the paper observation record.</p> <p>During an interview on 11/14/2024 at 2:05 PM with the PM 1, PM 1 stated on 11/7/2024, she was trying to open the door when Resident 7 walked by behind her trying to touch her buttock, but PM 1 noticed it right away and moved her hip aside avoiding being touched by Resident 7. PM 1 stated, she documented the incident in Resident 7 ' s care plan. PM 1 stated, there was no COC/SBAR, no updated interventions and no IDT held because he was already on q15 ' monitoring. PM 1 stated, a female resident could feel upset, angry and humiliated if being touched without her approval.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/14/2024 at 2:10 PM with the DSD, the DSD stated he was doing his round close to the change of shift when the licensed nurses were giving out medications and the residents were lining up. The DSD stated, he observed Resident 7 leaning over Resident 3 who was sitting at the bench. The DSD stated, Resident 7 was using his right hand to get close to Resident 3 ' s left groin. The DSD stated, he instantly walked up to both residents and interrupted Resident 7 by saying hello, hello. The DSD stated, Resident 7 stopped what he was doing and walked away.</p> <p>During an interview on 11/14/2024 at 2:20 PM with CNA 4, CNA 4 stated, she had about 10 residents to monitor for q15 ' . CNA 4 stated, she had to document resident q30 ' and every hour on top of working as a CNA giving care to her assigned residents. CNA 4 stated, based on her busy workload, when she monitored Resident 7 every 15 minutes, she would only glance at him to know where he was at and if he was safe or not. CNA 4 stated, there was a list of residents in the nursing station where the CNAs could see which residents were on q15 ' monitoring and the reason why they were being monitored.</p> <p>During a concurrent record review and interview on 11/14/2024 at 2:25 PM with CNA 4, Station 1 &amp; 2 Q15 ' /LOS list, dated 11/7/2024, was reviewed. CNA 4 stated, based on the list, Resident 7 had been monitored for elopement risk and socially inappropriate behavior. CNA 4 stated, there was no specific behavior noted for Resident 7 in the list. CNA 4 stated, socially inappropriate behavior was a board term which could mean that the resident had a habit of isolate himself in the room or not able to interact with other residents.</p> <p>During a concurrent record review and interview on 11/14/2024 at 2:35 PM with CNA 4, Resident 7 ' s Observation Record, dated 11/14/2024, was reviewed. CNA 4 stated, Resident 7 was monitored for behavior issue. CNA 4 stated, based on the record, there was no specific behavior documented to let the observer know what behavior to monitor for.</p> <p>During an observation and interview on 11/14/2024 at 2:45 PM with CNA 5, CNA 5 was holding at least 5 residents ' Observation Record, CNA 5 stated, she was documenting on her assigned residents for q15 ' monitoring. CNA 5 stated, she knew what behavior to monitor her residents for at the change of shift, and because she already knew her residents. CNA 5 stated, each resident had their own specific behavior issue that she needed to monitor them for, such as self-harm, sexually inappropriate behavior, fall risk, etc CNA 5 stated, if there was no specific behavior listed in the Observation Record, she would not know what to monitor when covering for another CNA during their break.</p> <p>During an interview on 11/14/2024 at 3:15 PM with the Program Counselor Quality Assurance Coordinator (PCQA), the PCQA stated, if an incident repeated every 3-4 months, it meant that the previous interventions only worked for a few months, so new interventions should be added and previous interventions should be revised.</p> <p>(continued on next page)</p>		

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  11/13/2024
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.			
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/14/2024 at 4:53 PM with the Director of Nurses (DON), the DON stated, it was ok for a male resident with known history of sexual inappropriate behavior to sit next to a female resident as far as they were on q15 ' monitoring, which allowed for 15 minutes of both residents not being monitored or supervised. The DON stated, Resident 7 was allowed to be close to female residents even when he was known to have sexual inappropriate behavior as evidenced by his history of for licking a female peer ' s ear on 4/10/2024, for groping a female peer ' s right breast on 10/23/2024, and for attempting to touch a female program manager ' s buttock on 11/7/2024 because it was the resident ' s right. The DON stated, regarding q15 ' monitoring, the assigned CNA did not need to know what specific behavior issue that the resident was placed on monitoring for, and just need to monitor all inappropriate behaviors. The DON stated, the CNA just needed to document any abnormal behavior to report to the program counselor department because all residents ' behavior problem was the PC ' s responsibility, not the nursing staff. The DON stated, it was the program counselor ' s responsibility to update and evaluate the interventions and care plan for each of the resident ' s behavior incidents.</p> <p>During a concurrent record review and interview on 11/14/2024 at 5:20 PM with the DON, Resident 7 ' s Post-Event Review, dated 10/23/2024 and Resident 7 ' s care plan was reviewed. The record indicated the IDT recommended Resident 7 ' s care plan updated as needed in the areas of behavior monitoring and supervision. The care plan indicated no documented behavior monitoring and supervision was updated. The DON stated, Resident 7 was already on q15 ' monitoring so they did not need further supervision.</p> <p>During a concurrent record review and interview on 11/14/2024 at 5:30 PM with the DON, Resident 7 ' s care plan was reviewed. The record indicated on 4/12/2024 Resident 7 ' s interventions included to advise the resident to stay away from female peers in order to prevent any incident from happening. The DON stated, they could not make Resident 7 stay away from the female peers because it would be so hard for him to do so. The DON stated, she stated the intervention was not practical for Resident 7 to follow.</p> <p>During an interview on 11/14/2024 at 6 PM with the Administrator (ADM), the ADM stated, the facility allowed hugging depending on the reactions of the female residents. The ADM stated, if the female residents kept silent, not speak up or shout, it meant that the female residents were ok with the hugging. The ADM stated, for Resident 7, due to his history of sexually inappropriate behavior that he liked to touch female residents and staffs, it was not ok for him to touch or hug other female residents. The ADM stated Resident 3 was not capable to consent to sex. The ADM stated, the staffs needed to intervene right away when Resident 7 tried to get close to any female residents or trying to hug them. The ADM stated, residents were placed on q15 ' monitoring for specific reason so she expected her staff to know and monitor the resident for the specific behavior problem, not just inappropriate behaviors in general. The ADM stated, based on Resident 7 ' s escalating in sexual inappropriate behavior, he should already be placed on line-of-sight on 10/23/2024 after he groped the female resident ' s right breast because their q15 ' monitoring was no longer working. The ADM stated, when Resident 7 tried to touch PM 1 ' s buttock on 11/7/2024, an IDT should have taken place and care plan should be reviewed/ revised to evaluate the interventions to manage his behavior. The ADM stated the incident on 11/13/2024 where he touched Resident 3 ' s groin should have been prevented.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2335 S. Mountain Ave Duarte, CA 91010	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s Policy and Procedure (P&amp;P) titled, Supervision and Precautions, dated October 2024, indicated all groups, meals, snacks and activities will be monitored by staff; Document assessment of patient's condition and precautionary measures and treatment plan provided for the patient's safety.</p> <p>During a review of the facility ' s P&amp;P titled, One to One Monitoring, dated October 2024, indicated facility provides one to one (1:1) monitoring when necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment to safeguard residents and staff, when deemed appropriate. Staff assigned for 1:1 responsibility will be trained on the purpose of the 1:1 monitoring based on resident need and condition, interventions/ measures to mitigate potential threat or danger.</p> <p>During a review of the facility ' s P&amp;P titled, Behavioral Health Services, dated February 2019, indicated residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. Staff training regarding behavioral health services includes but is not limited to: implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; monitoring care plan interventions.</p> <p>During a review of the facility ' s P&amp;P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>		