

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 11/20/2024
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 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>50012</p> <p>Based on observations, interview, and record reviews, the facility failed to maintain a hazard-free environment, assess for elopement (leaving the facility without notifying staff) risk upon admission, provide supervision and monitoring to one of one sampled resident (Resident 1) who eloped by climbing the roof of Building B, climbing the fence, jumping to the ground near the maintenance office, and climbing to another fence to reach the street and a gap between Building B and the fence that created an opening for Resident 1 to climb onto the roof and eloped on 11/18/2024 at 6:27 PM.</p> <p>As a result of this deficient practice ss 11/20/2024, Resident 1 remained missing and exposed the resident to significant risks, including falls, injuries associated with climbing, harm from motor vehicle traffic, and vulnerability to substance abuse.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, dated 11/12/2024, the face sheet indicated the facility admitted Resident 1 on 11/12/2024, with diagnoses including mild intellectual disabilities (condition where a person has an average mental age of between 9 and 12), and attention-deficit hyperactivity disorder (a neurodevelopmental disorder that affects a person's behavior, memory, motor skills, or ability to learn with symptoms that included inattention and hyperactivity).</p> <p>During a review of Resident 1 ' s History and Physical (H&P), dated 11/13/2024 indicated, Resident 1 had a history of substance abuse (use of illegal drugs or prescription or over-the-counter drugs or alcohol for purposes other than those for which they are meant to be used, or in excessive amounts).</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/17/2024, indicated Resident 1's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 1 was independent with eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, walk 150 feet.</p> <p>A review of the Elopement and Wandering Risk assessment dated indicated Resident! 1 was not at risk for wandering and elopement on 11/18/2024, there was no other documented evidence that an Elopement and Wandering Risk Assessment was conducted when Resident 1 was admitted to the facility.</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
---	-------	-----------

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 11/20/2024
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 0689</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 investigation report with the Administrator (ADM) 11/20/2024 at 9:20 AM, the report indicated on 11/18/2024 during the 6 PM core group session (a group activity for the residents) when Resident 1 approached a facility staff if he was able to participate in the community break (smoke break), the staff informed Resident 1 that he would not be allowed to attend the break. Resident 1 appeared to accept this decision and stated that he would go to bed. On 11/18/2024 at approximately 6:27 PM, Resident 1 stepped out of the group and was heard climbing onto the roof of Building B. facility staff immediately called a Code Green, (the facility's emergency code to alert staff of a missing or eloping resident) at approximately 6:30 PM on the same date. The report indicated, the facility staff observed Resident 1 running on the roof and then heard him climbing a fence next to Building B.</p> <p>According to the report, the facility staff heard Resident 1 jump to the ground near the Maintenance Office and proceeded to climb another fence located nearby the side street and the staff yelled for Resident 1 to stop, but the resident was not receptive. The report indicated Resident 1 continued to run, and staff eventually lost sight of the resident, unable to determine which direction the resident escaped to. The report indicated the police department were contacted, and upon their arrival at the facility, Resident 2 approached staff and reported that Resident 1 told him earlier that he planned to leave the facility and apologized for not informing staff sooner and stated he did not believe Resident 1 would actually follow through with his plan to leave.</p> <p>During a review of the Progress Notes, dated 11/18/2024, indicated, Resident 1 was observed attending pm core groups, socializing amongst peers and staffs, ate dinner and nourishment R At approximately 6:25 PM on 11/18/2024, Resident 1 successfully eloped. Prior to elopement, the note indicated Resident 1 was observed approached staff at 6pm and asked to join the core group and attend community break, the staff told him he would not be able to participate in community break due to a previous incident during the am shift. The report indicated, a few minutes after Resident 1 exited the group, staff (CR) called code green, and staff immediately assisted. Resident still has not been found.</p> <p>During an interview on 11/20/2024 at 9:05 AM, the ADM stated Resident 1 ' s incident of elopement was unexpected because the resident had not shown any prior signs of wanting to leave the facility. The ADM explained that Resident 1 appeared to have used a wall to climb onto the roof and exited the premises through an unfenced area on the side of the roof. Following the incident, the ADM stated she assessed the area and identified it as a potential area for residents to leave the facility that were at risk for elopement. The ADM further stated that staff acted according to protocol by initiating a Code [NAME] and attempting to redirect Resident 1. However, Resident 1 was not receptive and continued to elope. The ADM explained that staff are instructed not to chase residents to minimize additional risks, such as the resident running into traffic and potentially being struck by a vehicle.</p> <p>During a facility tour on 11/20/2024 at 10:25 AM, with Program Director 1 (PD1) demonstrated how Resident 1 climbed from the patio to the roof of Building B and although the roof was surrounded by a security fence, one side does not have a gate, and a gap a between the structure and the fence created an opening. In a concurrent interview, PD 1 stated the gap allowed Resident 1 to climb onto the roof and elope, exposing a critical safety vulnerability. According to PD1, a fence will be added to this area as part of the corrective action plan to prevent future elopements by residents.</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 11/20/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/2024 at 10:35 AM, PD 1 stated, on 11/18/2024 on the morning before Resident 1 eloped, the resident was calm and participated fully in all scheduled activities and did not show any signs or express any interest in leaving the facility, the resident was moved to a different room for his safety after reports that Resident 1 attemptrd to have sexual contact with another female resident who had no capacity to make decision for herself. PD 1 stated Resident 1 was receptive to the move and continued attending activities throughout the day, showing no signs of distress or elopement risk.</p> <p>During an interview on 11/20/2024 at 12:30 PM, with Resident 2, Resident 2 stated Resident 1 approached him one time and expressed a desire to leave the facility and Resident 1 invited him to join. Resident 2 stated Resident 1 did not provide any specific details or outlined a plan for how he intended to elope, but only stated he wished to leave. Resident 2 stated that he chose not to report this information at the time because he did not perceive it as necessary or urgent. Additionally, Resident 2 explained that he did not want to get involved in the situation.</p> <p>During an interview on 11/20/2024 at 12:55 PM, the ADM stated Resident 1 had not returned to the facility but Resident 1 ' s family member (FAM 1) informed her that Resident 1 contacted her to inform her that he (Resident 1) was okay, but did not disclose his location. The ADM the police department was informed and will maintain open communication with FAM 1.</p> <p>On 11/20/2024 multiple attempts were conducted by the surveyor and the ADM to contact the staff that witnessed Resident 1 climbing the fence and eloped, but the calls were not answered by the staff.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision, indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.</p> <p>A review of the facility ' s policy titled, Elopement Precautions, dated 7/19/19, indicated that the facility grounds are secured with locked fences, to minimize elopement from the facility.</p>		