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	02/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on observation, interview and record review, the facility failed to provide supervision for one of three sampled residents (Resident 2), with history of sexually inappropriate behaviors toward others, by failing to protect Resident 2 when Resident 1 wandered inside Resident 2 ' s room on 1/31/2025, in accordance with Resident 2's care plan. On 1/31/2025 at 8:40 PM, Certified Nurse Assistant (CNA) 1 witnessed Resident 1 on Resident 2 ' s bed, kissing Resident 1 on the lips. Resident 2 verbalized that Resident 1 had also touched her private area without consent. This deficient practice resulted in Resident 4, 5, and 7 to experience physical abuse that may result to the residents ' psychosocial well-being and to not feel safe at the facility. Findings: During a review of Resident 1 ' s Admission Record [AR], the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (mental illness can combines disorganized thinking and inappropriate behavior) and intermittent explosive disorder (a condition that involves impulsive and aggressive outburst). During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the Patient ' s health status) signed by the attending physician on 11/29/2024, the HPE indicated Patient 1 had a mental illness. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 11/10/2024, the MDS indicated the Resident 1 had intact cognition (thought process). (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s care plans titled Behavioral symptoms: Sexual inappropriate/disruptive behavior towards others. The care plan indicated on 1/30/2022, Resident 1 touched a female resident breast. The care plan indicated another incident on 8/1/2022 where Resident 1 grabbed a female resident breast. The care plan indicated another incident on 8/21/2023 where Resident 1 kissed and touched a female resident and told her not to say anything. The care plan indicated another incident on 9/15/2023 where Resident 1 touched a female resident buttock during group activity. The care plan indicated another incident on 1/31/2025 where Resident 1 had a sexually inappropriate behavior towards a female resident. During a review of Resident 1 ' s Change in Condition (COC) dated 1/31/2025 timed at 11:17 PM, the COC indicated that Resident 1 had a sexually inappropriate behavior. During a review of Resident 1 ' s Post Event Review (PER) notes dated 2/3/2025 timed at 1:38PM, the PER indicated that an Interdisciplinary Team met to discuss Resident 1 sexually inappropriate behavior towards Resident 2. The PER indicated that Resident 1 entered Resident 2 ' s room and kissed her. During a review of Resident 1 ' s Handwritten Sexual Consent note undated, given to Resident 2 indicated that Resident 1 made love with Resident 2 consensually both were okay with the following terms and or activities: kissing, oral or anal sex and love making. During a review of Resident 2 ' s AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included mild intellectual disabilities (condition that affects a person ' s ability to learn and think) and intermittent explosive disorder. During a review of Resident 2 ' s HPE, signed by the attending physician on 1/31/2025, the HPE indicated Patient 1 had a mental illness. During a review of Resident 2 ' s Change in Condition (COC) dated 1/31/2025 timed at 11:38PM, the COC indicated that Resident 2 was the victim of a sexually inappropriate behavior. During a review of Resident 2 ' s Post Event Review (PER) notes dated 2/2/2025 timed at 1:51 PM, the PER indicated that an Interdisciplinary Team met to discuss Resident 1 sexually inappropriate behavior towards Resident 2. The PER indicated that Resident 1 entered her room without permission and kissed her During a review of Resident 1 ' s Progress Notes dated 2/1/2025 timed at 12:14AM, indicated on 1/31/2025 at 8:40 PM Resident 1 was not in his room in the B building and Certified Nursing Assistant (CNA) 1 had seen Resident 1 in building C near the Shower Room. The progress note indicated at 8:41 PM CNA 1 reported to Program Counselor (PC) 2 that Resident 1 was seen in building C. The progress note indicated PC 2 contacted PC 3 who was watching the nursing station/courtyard in building C. The progress note indicated at 8:43PM PC 3 decided to do a safety room check starting with Resident 2 room. The progress note indicated that PC 3 found Resident 1 in bed with Resident 2 under the covers. The progress note indicated PC 3 asked Resident 1 what was he doing, Resident 1 did not answer and got out of bed and walked out of Resident 2 ' s room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of CNA 1 ' s Handwritten Investigation Statement dated 1/31/2025, indicated CNA 1 that at 8:30 PM she witnessed Resident 1 at the entrance of building C. CNA 1 further wrote that she told Resident 1 to go back to his room and she saw Resident 1 walk back to his room, after that. During a review of PC 1 Handwritten Investigative Statement dated 1/31/2025, indicated PC 1 stated that at 8:40PM he overheard CNA 1 report to PC 2 that CNA 1 saw Resident 1 at the entrance to building C. PC 1 further wrote he prompted PC 3 to check on the residents on his assigned area in building C. PC 1 further wrote that PC 3 approached Resident 2 room and when he entered Resident 1 was in bed with Resident 2 with their clothes on. During a review of PC 2 Handwritten Investigative Statement dated 1/31/2025, indicated at 8:40 PM PC 2 was at the program manager ' s office with PC 1. PC 2 further wrote that CNA 1 had reported that Resident 1 was in building C waiting to speak with someone. PC 2 further wrote PC 1 prompted PC 3 to check on the residents in building C to ensure the residents were safe. PC 2 further wrote that Resident 1 was found in Resident 2 ' s room in bed with her. During a review of PC 3 Handwritten Investigative Statement dated 1/31/2025, indicated PC 3 was notified by PC 1 at 8:42 PM to keep an eye on Resident 1. PC 3 further wrote he then went to Resident 1 room in building B and Resident 1 Was not in his room. PC 3 further wrote he went into building C to do a safety check on the female resident ' s rooms. PC 3 further wrote he first checked Resident 2 ' s room and found Resident 1 in bed with Resident 2 covered with a blanket. PC 3 further wrote Resident 2 was lying flat in bed and Resident 1 was lying down on his left side facing Resident 2. PC 3 further wrote when he questioned Resident 1, Resident 1 did not respond then stood up and walked out and back to his room. During a review of PC 4 Handwritten Investigative Statement dated 1/31/2025, indicated PC 4 was monitoring all the residents in building B and saw Resident 1 leave his room to go to the dining room and was talking with CNA 1. During a review of the facility ' s Unusual Occurrence Reporting Form dated 2/3/2025, indicated on 1/31/2025 at 8:40 AM, CNA 1 saw Resident 1 standing near Building C male shower room. The form indicated that CNA 1 told Resident 1 to return to his room and at approximately 8:41 PM, CNA 1 went to the program office to notify PC 2 and PC 1. The form indicated at 8:42 PM PC 1 notified PC 3 who was watching Building C and the courtyard that Resident 1 was seen in Building C. The form indicated at 8:43 PM PC 3 decided to do a resident safety check and went to Resident 2 ' s room. The form indicated when Resident 2 was questioned she stated that she signed a letter but did not know what she signed because was half asleep. The form indicated that Resident 2 stated that Resident 1 kissed her on the mouth and touched her private area over her pants. The form indicated that Resident 2 stated the sexual act was not consensual. The form indicated that Resident 2 wanted to press charges against Resident 1. The form indicated that on 2/2/2025 law enforcement came to the facility to investigate the sexual abuse complaint and when they interviewed Resident 1, he stated to the police I plead the fifth. The form indicated that the police stopped the interview and transferred the case to suspicious circumstance sexual battery and a detective would be coming to the facility to follow up the investigation. During a review of the Report Information and Victims [NAME] of Rights dated 2/3/2025, indicated Police Officer (PO) 1 and labeled the incident as suspicious circumstances sexual battery. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/2025 at 9:45AM, the Administrator (ADM) stated that Resident 1 had entered Resident 2 room unwitnessed by staff. The ADM stated that Resident 1 had kissed Resident 2 on the lips, and he was touching Resident 1 private area and both residents were clothed. The ADM stated that Resident 1 had a history of sexual inappropriate behavior of touching female residents such as kissing and touching their breast and vagina while clothed. The ADM stated that Resident 1 was not on any special monitoring such as 1:1 supervision prior to the incident on 1/31/2025. The ADM stated that Resident 1 will be on 1:1 monitoring until they find placement for a higher level of care. The ADM stated that Resident 2 had filed charges with the Sheriff ' s Dept for sexual battery against Resident 1. The ADM stated that the afternoon of the incident, the counselors and nursing staff should have been watching Resident 1 ' s closely but did not, which led to Resident 1 entering Resident 2 ' s room undetected, and sexually abusing Resident 2 by kissing her lips and touching her private area without her consent. The ADM stated that Resident 1 wrote a handwritten consent and Resident 2 initialed it without knowing what the purpose of the consent was for. The ADM stated that Resident 1 consent was not a legal consent and stated that the social worker does the consent form with a witness if two residents want to consent to have sexual intercourse. During an interview on 2/4/2025 at 10:00 AM, Resident 2 stated that Resident 1 had entered her room late at night on 1/31/2025. Resident 2 stated that Resident 1 made her sign a piece of paper that was for sex and she was half asleep. Resident 2 stated she did not want to be touched, kissed or have sex with Resident 1. Resident 2 signed the paper because she was in fear and in a state of shock. Resident 2 did not scream for help because she was in shock and did not want to wake the other residents. Resident 2 stated that she was in the room alone prior to Resident 1 entering the room. Resident 2 stated that after she initialed the paper that Resident 1 pulled the bed sheet over their heads and Resident 1 began to kiss her on the lips and with his right hand was touching her private area in an up and down motion. Resident 2 stated that Resident 1 was in the room with her alone with Resident 1 for a few minutes before a staff member entered the room and asked Resident 1 what he was doing. Resident 2 stated that Resident 1 just left the room after being questioned by the staff. Resident 2 stated that she was pressing a sexual assault charge against Resident 1. During an interview on 2/4/2025 at 11:25 AM, the Program Director (PD) stated that on 1/31/2025 she spoke with the nursing staff and counselors for the 3PM -11PM shift prior to leaving the facility at around 4PM that the staff were supposed to monitor Resident 1 closely for inappropriate sexual behavior towards any of the female residents. PD stated that her staff failed to monitor Resident 1 because he was able to find a way into Resident 2 room and started kissing her lips and touching her private area without her consent. PD stated that Resident 1 had a handwritten consent was not a legitimate. PD stated that this occurrence could have been prevented had the facility staff listened to her specific instructions to monitor Resident 1 closely. PD stated that prior to this incident Resident1 was not on any 1:1 monitoring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/2025 at 11:43 AM, the Program Manager (PM) stated that she worked on 1/31/2025 and left the facility at around 8:15 PM. PM stated that she did a walk thru the entire bungalow area prior to exiting the facility and Resident 1 was in his room at the time. PM stated at 8PM residents are in their rooms for room relaxation time. PM stated at 8:53 PM she received a text message from PC 1 regarding Resident 1 entering Resident 2 ' s room and Resident 1 had kissed Resident 2 on the lip ' s and he had touched Resident 2 in her private area. PM stated that PC 1 had sent her a picture of Resident 1 handwritten consent form to have sex with Resident 2. PM stated that the consent form was not a legitimate form. PM stated when she interviewed Resident 1, he stated that her staff was stupid and did not see him enter Resident 2 room. PM stated at 8:40PM CNA 1 had redirected Resident 1 to go back to his room turned her back and went to report Resident 1 to PC 1 and PC2. PM stated PC1 notified PC3 who was supposed to be watching Building C and the courtyard. PM stated at 8:43PM PC 3 did a safety check in building C knocked on Resident 2 room and found Resident 1 and Resident 2 under the covers in bed together. PM stated that Resident 2 stated that the sexual act was not consensual, and they were not boyfriend & girlfriend. PM stated that Resident 2 was pressing charges of sexual battery with the Sheriff ' s Dept. During a phone interview on 2/4/2025 at 2:46PM, PC 3 stated that PC 4 was in charge of watching the residents in building B at 8 PM and that Resident 1 room was in building B. PC 3 stated he was in charge of watching the female residents in Building C and the courtyard. PC 3 stated at around 8:46 PM or 8:47 PM he was notified by PC 1 that Resident 1 was seen near the shower rooms in building C. PC 3 stated he went to do a safe check in Building C and went to Resident 2 ' s room because she was a new resident to the facility and Resident 1 had a history of inappropriate sexual behavior towards female residents. PC 3 stated when entered Resident 2 ' s room that Resident 1 was in bed with Resident 2, and they were both covered with a bed sheet. PC 3 stated that Resident 1 then got out of Resident 2 bed and walked away to his room. During a review of the facility ' s P&P titled Supervision and Precautions revised 2/21/2022, indicated daily supervision, dangerous behavior precaution, non-consenual sexual behavior and precautions are actions taken by the nursing/program staff to protect a patient from attempts of dangerous behavior and to ensure observation of the patient. The policy indicated nursing and program staff will provide daily supervision to assist with needs of the Patients hourly unless closer supervision is needed. During a review of the facility's P&P titled Care Plans: Nursing dated 12/2024, indicated To ensure that the medical of the clients are met as the client's physical well-being is of utmost concern while in treatment. The policy indicated implementing of each client's care plan.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to provide sufficient staff to monitor and supervise two of four sampled residents (Resident 3 and 4) in the hallways. This deficient practice had resulted in Resident 4 was hit by Resident 3 on 1/22/2025 and Resident 4 stated she was afraid that Resident 3 would hit her again and wanted Resident to go away. Findings: During a review of Resident 3 ' s Admission Record indicated the facility admitted Resident 3 on 1/30/2020 with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and hyperlipidemia (A condition in which there are high levels of fat particles in the blood). During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/6/2024, indicated Resident 3 had moderately impaired cognition (ability to think and reason) and memory. The MDS indicated Resident 3 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene. During a review of Resident 3 ' s Progress Notes-Physician ' s Order Note, dated 1/5/2025, indicated Resident 3 had behavioral incidents of hitting peers. During a review of Resident 3 ' s Change in Condition (COC), dated 1/22/2025, indicated a female resident alleged that Resident 3 punched her in the right side of face. During a review of Resident 3 ' s Progress notes-Health Status Note, dated 1/22/2025, indicated At approx. 2:10 pm, Female Peer approached Male Counselor and reported that Resident had hit her on the side of the face x 1 in the hallway near Saturn room. Female Peer stated that she was walking in the hallway when Resident walked by her and punched her. During a review of Resident 4 ' s Admission Record indicated the facility admitted Resident 4 on 10/12/2022 with diagnoses that included schizophrenia and hypertension (high blood pressure). During a review of Resident 4's MDS, dated [DATE], indicated Resident 4 had moderately impaired cognition (ability to think and reason) and memory. The MDS indicated Resident 4 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene. During a review of Resident 4 ' s Physician Order, dated 1/22/2025, indicated the physician ordered to place ice pack for 15 minutes to right ear one time, place on 72 hours neuro check one for three days, and place on every 15 minutes monitoring for safety for 72 hours for three days. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4 ' s COC, dated 1/22/2025, indicated Resident 4 Alleged that male peer punched her in the right side of face x1 and slight redness to right side of face near right ear noted. During a review of Resident 4 ' s Progress Notes-Health Status Note, dated 1/22/2025, indicated At approx. 2:10pm, Resident approached Male Counselor and reported that Male Peer had hit her on the side of the face x 1 in the hallway near Saturn room. Resident stated that she was walking in the hallway when Male Peer walked by her and punched her . Resident c/o (complained of) 1/10 pain to right side of face .Slight redness noted to right side of face near right ear. During an interview on 2/4/2025 at 10:59 AM with Primary Counselor (P) 5, PC 5 stated on 1/22/2025 around 2:10 PM, he was around the Nursing Station 1 and did not remember what he was doing around the area at that time. PC 5 stated Resident 4 approached him and told him Resident 3 walked by her in the hallway outside the Saturn room and punched her right side of face around the ear, then, Resident 3 walked past her and walked away. PC 5 stated he did not witness the alleged incident. PC 5 stated Resident 4 expressed she did not feel safe in the facility. PC 5 stated Resident 4 was usually kept to herself and would not provoke an altercation with another resident. PC 5 stated Resident 3 had history of striking on female residents before and he was very unpredictable. PC 5 stated the Mental Health Workers (MHW) were responsible for monitoring the hallways and the Certified Nursing Assistants (CNA) were responsible for making their rounds and making beds. During an interview on 2/4/2025 at 12:34 PM with PC 6, PC 6 stated Resident 3 had a history of suddenly striking and hitting other female residents in the past. PC 6 stated Resident 3 was on every 15 minutes monitoring to ensure the staff knew where his about and what he was doing on 1/22/2025 before the alleged incident occurred because his aggressive behavior history. PC 6 stated the CNAs were responsible for every 15 minutes monitor for Resident 3. During an interview on 2/4/2025 at 12:51 PM with MHW 1, MHW 1 stated she did not witness the alleged incident between Resident 3 and Resident 4 on 1/22/2025. MHW 1 stated the building had four hallways forming a rectangle shape and three MHWs were supposed to assign each shift to monitor the floor with one staying in Nursing Station 2 and other two walking down the hallways. MHW 1 stated she was the only one assigned to monitor the floor on 1/22/2025. MHW 1 stated it took about six minutes to walk one round to cover all four hallways and one staff was not enough to monitor the floor. MHW 1 stated the CNAs did not monitor the floor and she was the only one monitor the floor during the day shift on 1/22/2025. MHW 1 stated she was also assigned to supervise nourishment in the dining room at 2 PM on 1/22/2025. MHW stated usually when she was supervising nourishment, one PC would replace her, but she did not know which PC replaced her to monitor the floor after she left to supervise nourishment at 2 PM on 1/22/2025. During a concurrent interview and record review on 2/4/2025 at 1:02 PM with the Special Treatment Program Director (STPD), Schedule-Floor Monitoring, dated 1/22/2025, and STP Program Schedule, dated 1/22/2025, were reviewed. The STPD stated the facility usually assigned two to three staff to monitor the floor each shift, but MHW was the only one assigned to monitor the floor during the day shift on 1/22/2025. STPD stated one staff to monitor all four hallways was not enough. STPD stated from 1:45 PM to 2:40 PM on 1/22/2025, the PCs was providing a group activity for the residents in the center courtyard and some PCs were inside the building to ask resident to attend the activities around 2 PM, but she did not know if a PC or which PC was assigned to replace MHW 1 to monitor the floor. STPD stated no PCs witnessed the alleged incident between Resident 3 and 4 on 1/22/2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/4/2025 at 1:18 PM with CNA 2, Resident 3 ' s Observation Record, dated 1/22/2025, was reviewed. CNA 2 stated she was responsible to do Every 15 Minutes Monitor on Resident 3 before the alleged incident occurred on 1/22/2025. CNA 2 stated she checked Resident 3 and he was inside his room around 2 PM, then, she checked Resident 3 and he was inside his room around 2:15 PM. CNA 2 stated she was checking Resident 3 every 15 minute, but she was not monitoring Resident 3 every minute, so she would not know what Resident 3 did between 2PM and 2:15 PM and she did not witness the alleged incident on 1/22/2025. CNA 2 stated she was not responsible to monitor the hallways. During an interview on 2/4/2025 at 1:35 PM with Resident 4, Resident 4 stated on 1/22/2025, she was walking in the hallway outside the Saturn Room, Resident 4 suddenly walked up next to her from her behind and punched her right side of face, the Resident 4 walked past her. Resident 4 stated she was worried that Resident 3 would hit her again and she wanted Resident 3 to go away. During a concurrent interview and record review on 2/4/2025 at 2:30 PM with the Administrator (ADM), Schedule-Floor Monitoring, dated 1/22/2025 and 2/4/2025, and STP Program Schedule, dated 1/22/2025, were reviewed. The ADM stated only one MHW was assigned to monitor the floor and cover all four hallways during the day shift on 1/22/2025 because call offs and to cover last minute line of sight (one on one) monitoring. The ADM stated three MHWs should be scheduled to monitor the floor at all times, with one MHW staying in the corner of Nursing Station 2 and other two MHWs patrolling the four hallways, to ensure residents ' safety. During a review of the facility ' s policy and procedure (P&P) titled, Community Care-Safety and Supervision of Residents, dated 12/2007, indicated Resident supervision is a core component of the systems approach to safety. During a review of the facility ' s P&P titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, indicated the facility provided sufficient numbers of staff to ensure residents ' needs are met. Based on interview and record review, the facility failed to provide sufficient staff to monitor and supervise two of four sampled residents (Resident 3 and 4) in the hallways. This deficient practice had resulted in Resident 4 was hit by Resident 3 on 1/22/2025 and Resident 4 stated she was afraid that Resident 3 would hit her again and wanted Resident to go away. Findings: During a review of Resident 3's Admission Record indicated the facility admitted Resident 3 on 1/30/2020 with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and hyperlipidemia (A condition in which there are high levels of fat particles in the blood). During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/6/2024, indicated Resident 3 had moderately impaired cognition (ability to think and reason) and memory. The MDS indicated Resident 3 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Progress Notes-Physician's Order Note, dated 1/5/2025, indicated Resident 3 had behavioral incidents of hitting peers. During a review of Resident 3's Change in Condition (COC), dated 1/22/2025, indicated a female resident alleged that Resident 3 punched her in the right side of face. During a review of Resident 3's Progress notes-Health Status Note, dated 1/22/2025, indicated At approx. 2:10 pm, Female Peer approached Male Counselor and reported that Resident had hit her on the side of the face x 1 in the hallway near Saturn room. Female Peer stated that she was walking in the hallway when Resident walked by her and punched her. During a review of Resident 4's Admission Record indicated the facility admitted Resident 4 on 10/12/2022 with diagnoses that included schizophrenia and hypertension (high blood pressure). During a review of Resident 4's MDS, dated [DATE], indicated Resident 4 had moderately impaired cognition (ability to think and reason) and memory. The MDS indicated Resident 4 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene. During a review of Resident 4's Physician Order, dated 1/22/2025, indicated the physician ordered to place ice pack for 15 minutes to right ear one time, place on 72 hours neuro check one for three days, and place on every 15 minutes monitoring for safety for 72 hours for three days. During a review of Resident 4's COC, dated 1/22/2025, indicated Resident 4 Alleged that male peer punched her in the right side of face x1 and slight redness to right side of face near right ear noted. During a review of Resident 4's Progress Notes-Health Status Note, dated 1/22/2025, indicated At approx. 2:10pm, Resident approached Male Counselor and reported that Male Peer had hit her on the side of the face x 1 in the hallway near Saturn room. Resident stated that she was walking in the hallway when Male Peer walked by her and punched her . Resident c/o (complained of) 1/10 pain to right side of face .Slight redness noted to right side of face near right ear. During an interview on 2/4/2025 at 10:59 AM with Primary Counselor (P) 5, PC 5 stated on 1/22/2025 around 2:10 PM, he was around the Nursing Station 1 and did not remember what he was doing around the area at that time. PC 5 stated Resident 4 approached him and told him Resident 3 walked by her in the hallway outside the Saturn room and punched her right side of face around the ear, then, Resident 3 walked past her and walked away. PC 5 stated he did not witness the alleged incident. PC 5 stated Resident 4 expressed she did not feel safe in the facility. PC 5 stated Resident 4 was usually kept to herself and would not provoke an altercation with another resident. PC 5 stated Resident 3 had history of striking on female residents before and he was very unpredictable. PC 5 stated the Mental Health Workers (MHW) were responsible for monitoring the hallways and the Certified Nursing Assistants (CNA) were responsible for making their rounds and making beds. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	2335 S. Mountain Ave Duarte, CA 91010

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 12:34 PM with PC 6, PC 6 stated Resident 3 had a history of suddenly striking and hitting other female residents in the past. PC 6 stated Resident 3 was on every 15 minutes monitoring to ensure the staff knew where his about and what he was doing on 1/22/2025 before the alleged incident occurred because his aggressive behavior history. PC 6 stated the CNAs were responsible for every 15 minutes monitor for Resident 3. During an interview on 2/4/2025 at 12:51 PM with MHW 1, MHW 1 stated she did not witness the alleged incident between Resident 3 and Resident 4 on 1/22/2025. MHW 1 stated the building had four hallways forming a rectangle shape and three MHWs were supposed to assign each shift to monitor the floor with one staying in Nursing Station 2 and other two walking down the hallways. MHW 1 stated she was the only one assigned to monitor the floor on 1/22/2025. MHW 1 stated it took about six minutes to walk one round to cover all four hallways and one staff was not enough to monitor the floor. MHW 1 stated the CNAs did not monitor the floor and she was the only one monitor the floor during the day shift on 1/22/2025. MHW 1 stated she was also assigned to supervise nourishment in the dining room at 2 PM on 1/22/2025. MHW stated usually when she was supervising nourishment, one PC would replace her, but she did not know which PC replaced her to monitor the floor after she left to supervise nourishment at 2 PM on 1/22/2025. During a concurrent interview and record review on 2/4/2025 at 1:02 PM with the Special Treatment Program Director (STPD), Schedule-Floor Monitoring, dated 1/22/2025, and STP Program Schedule, dated 1/22/2025, were reviewed. The STPD stated the facility usually assigned two to three staff to monitor the floor each shift, but MHW was the only one assigned to monitor the floor during the day shift on 1/22/2025. STPD stated one staff to monitor all four hallways was not enough. STPD stated from 1:45 PM to 2:40 PM on 1/22/2025, the PCs was providing a group activity for the residents in the center courtyard and some PCs were inside the building to ask resident to attend the activities around 2 PM, but she did not know if a PC or which PC was assigned to replace MHW 1 to monitor the floor. STPD stated no PCs witnessed the alleged incident between Resident 3 and 4 on 1/22/2025. During a concurrent interview and record review on 2/4/2025 at 1:18 PM with CNA 2, Resident 3's Observation Record, dated 1/22/2025, was reviewed. CNA 2 stated she was responsible to do Every 15 Minutes Monitor on Resident 3 before the alleged incident occurred on 1/22/2025. CNA 2 stated she checked Resident 3 and he was inside his room around 2 PM, then, she checked Resident 3 and he was inside his room around 2:15 PM. CNA 2 stated she was checking Resident 3 every 15 minute, but she was not monitoring Resident 3 every minute, so she would not know what Resident 3 did between 2PM and 2:15 PM and she did not witness the alleged incident on 1/22/2025. CNA 2 stated she was not responsible to monitor the hallways. During an interview on 2/4/2025 at 1:35 PM with Resident 4, Resident 4 stated on 1/22/2025, she was walking in the hallway outside the Saturn Room, Resident 4 suddenly walked up next to her from her behind and punched her right side of face, the Resident 4 walked past her. Resident 4 stated she was worried that Resident 3 would hit her again and she wanted Resident 3 to go away. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	2335 S. Mountain Ave Duarte, CA 91010

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/4/2025 at 2:30 PM with the Administrator (ADM), Schedule-Floor Monitoring, dated 1/22/2025 and 2/4/2025, and STP Program Schedule, dated 1/22/2025, were reviewed. The ADM stated only one MHW was assigned to monitor the floor and cover all four hallways during the day shift on 1/22/2025 because call offs and to cover last minute line of sight (one on one) monitoring. The ADM stated three MHWs should be scheduled to monitor the floor at all times, with one MHW staying in the corner of Nursing Station 2 and other two MHWs patrolling the four hallways, to ensure residents' safety. During a review of the facility's policy and procedure (P&P) titled, Community Care-Safety and Supervision of Residents, dated 12/2007, indicated Resident supervision is a core component of the systems approach to safety. During a review of the facility's P&P titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, indicated the facility provided sufficient numbers of staff to ensure residents' needs are met.