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	06/28/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49998 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 41) was provided dignity and respect by providing privacy and ensuring the resident did not walk naked in the hallway. This failure had a potential to result to feelings of embarrassment, humiliation, loss of dignity, loss of privacy for Resident 41 and could make other residents uncomfortable. Finding: A review of Resident 41's Admission record (Face Sheet), indicated the facility admitted Resident on 2/11/2022 with diagnoses that included paranoid schizophrenia (mental illness that include hallucinations [false perceptions of reality such as hearing voices or seeing images that are not real] and/or delusions [fixed, false beliefs that conflict with reality]) and unspecified schizoaffective disorder (a mix of schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] symptoms such as hallucinations, delusions and mood disorder symptoms). A review of Resident 41's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 5/20/2024, indicated Resident 41's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, had inattention (difficulty focusing attention). The MDS indicated Resident 41 suffered from hallucinations, delusions, and inattention (difficulty focusing attention, being easily distractible, having difficulty keeping track of what was being said). The MDS indicated Resident 41required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) with eating, oral and personal hygiene and walking 10 feet. During an interview on 6/25/2024 at 10 A.M, Certified Nurse Assistant (CNA) 5 stated she observed Resident 41 came out of his (Resident 41) room naked and walked into the hallway and up to the Nurse ' s Station 2 on 5/2/2024 at 5:37 P.M. During an interview on 6/27/2024 at 11:09 A.M., Resident 41 stated he usually hung out in the hallway and walked around the hallway during dinner time. Resident 41 stated he does not remembered walking naked in the hallway. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/2024 at 12 P.M., Patient Counselor (PC) 1 stated Resident 41 walked naked in the hallway around 1st week of May 2024 (May 2, 2024). PC 1 stated when he got to Nursing Station 2, he saw Resident 41 followed a female Resident (Resident 25) while Resident 41 was naked, and he (PC 1) immediately redirected Resident 41 to Resident 41 Room. PC1 stated he assisted Resident 41 to walked back to Resident 41 Room while Resident 41 was still naked and uncovered. PC1 stated, Resident 41 said he just wanted to talk to the female resident (Resident 25). PC 1 stated he redirected Resident 41 and told him he cannot talk to the female residents while naked. During an interview on 6/28/2024 at 1 P.M., the DSD stated the staff should not allow Resident 41 from walking in the hallway naked. The DSD stated walking naked in the facility could be embarrassing, offensive and uncomfortable to other residents and could lead to altercation. The DSD stated he needed to educate staff to ensure to closely monitor residents and ensure that residents were not walking naked in the hallway. The DSD stated the facility needed to ensure to preserve the residents ' dignity and prevent possible abuse. During an interview on 6/28/2024 at 2:00 P.M., LVN 9 stated one CNA (unidentified) called for assistance due to Resident 41 was outside his room naked and was standing in the hallway. LVN 9 stated Resident 41 was staring at a female resident (Resident 74) and approached her while Resident 41 was naked. LVN 9 stated PC 1 came and redirected Resident 41 back to room and put on clothing. During an interview on 6/28/2024 at 3:30 P.M., the DON stated the staff (unable to recall name) informed her that Resident 41 walked naked from Resident 41 Room to Nursing 2 station fully naked. The DON stated Resident 41 Room was too far away from Nursing Station 2 and the hallway monitor should have seen Resident 41 when he walked out of his room naked and stopped Resident 41 from walking without clothes on. The DON stated the staff should have not allowed Resident 41 to walked in the hallway naked to ensure to preserve Resident 41 ' s dignity and also to protect other residents ' safety and from being uncomfortable. A review of Resident 41 ' s care plan for safe sex practice, date initiated 2/14/2022, indicated Resident 41 will be able to understand safe sex practice. The care plan indicated to educate resident on safe sex practices and to provide oversite supervision and monitoring for safety. A review of Resident 41 ' s nursing progress notes, dated 5/2/2024 at 5:17 P.M., indicated Resident 41 came out of his room naked and approached female peer, just standing there staring at her. Resident 41 was redirected back to his room and provided 1:1 counseling. Resident 41 was placed on 72- hour monitoring. A review of Resident 41 ' s Change in Condition Evaluation form dated 5/2/2024 at 5:35 PM, indicated Resident 41 had behavioral changes and had episode of indecent exposure (the intentional or reckless act of exposing private body parts in public or in a setting where others may be offended). A review of Resident 41's SBAR (situation, background, assessment, recommendation) Communication Form, indicated that on 5/2/2024, Resident 41 had change in condition in behavioral symptoms, had indecent exposure and was placed on 72-hour observation. A review of Resident 41's care plan for socially inappropriate behavior manifested by disrobing (take off one's clothes) in hallways, date initiated 5/3/2024, indicated Resident 41 came out of his room naked on 5/2/2024. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 41's Program Counselor progress notes, dated 5/3/2024 at 3:58 P.M., indicated Resident 41 was given one to one (1:1-individual) counseling to discuss the incident where he walked outside his room naked. The progress notes indicated Resident 41 stated Did I do that? I do not remember if I did. A review of the facility's policy and procedure (P&P) titled, Privacy/Dignity, (undated) indicated all employes shall treat resident ' s families and visitors and fell ow workers with kindness, respect, and dignity. Always ensure privacy/or dignity of residents is respected during care and during conversations with residents. A nursing home resident has the right to personal privacy of not only his/her own physical body, but also his/her personal space, including accommodations and personal care. A review of the facility's P&P titled, Resident Monitoring - Rounds, (undated), indicated the facility maintains a policy, procedure, and practices to ensure Resident Safety. The procedure and practices will provide safety through observations by responsible staff. The purpose of making rounds is to ensure appropriate resident care, resident safety, and maintenance of the facility. Frequent rounds may be assigned to a certain resident in relation to a specific concern or problem that requires closer supervision.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36925 Based on observation, interview, and record review, the facility failed to provide a functional, safe, and clean environment for the rooms frequented by residents in the facility, by failing to: 1. Keep the paper towel dispensers in rooms [ROOM NUMBERS] in good working condition. 2. Fix and paint the ceiling of the main Dining Room that had a water leak. These deficient practices had the potential to expose the residents to accidents and health problems. 3.Ensure Resident 135 was provided with comfortable and homelike environment by failing to refill the paper towel and maintain a functional paper towel dispenser in the resident ' s restroom. This failure resulted in Resident 135 ' s feeling upset and dirty after washing his hands with no paper towel to dry them. 4. Maintain a comfortable and safe temperature levels and maintain a temperature range of 71 to 81 degrees Fahrenheit (F) (a scale for measuring temperature) in the Big Dining/Activity (BDA) room in the Building 1 (B1) This deficient practice had the potential to affect the Residents of the B1 and negatively affect their health and mood behavior and affect their quality of life. Findings: 1. During an observation on 06/25/2024 at 10:02 AM, rooms [ROOM NUMBERS] had a paper towel dispenser that was not working. During an interview on 06/26/24 at 07:50 AM, the Maintenance Supervisor (MS) stated that he already fixed the paper towel dispenser in rooms [ROOM NUMBERS] since the residents need it to dry their hands after washing. 2. During the facility's dining observation in the Dining Room area, on 06/25/24 12:43 PM, a water stain in the ceiling of the Dining Room was observed. During an interview on 06/26/24 at 8:01 AM, the MS stated that when it was raining hard a month ago, rainwater leaked from the roof and damaged the ceiling. The MS stated they found a hole on the roof and sealed it. After fixing the roof, the MS stated he replaced the dry wall in the ceiling and painted it. However, the MS stated it rained again days later and another rainwater leak from the roof damaged the ceiling. The MS stated he was not able to fix the problem right away. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/24 at 08:25 AM, Certified Nurse Assistant (CNA 8) stated that they had to move the tables and chairs to the side of the dining room a few weeks ago since water was leaking from the ceiling. She stated the maintenance staff fixed the leak, but they did not paint the ceiling after they repaired it. A review of the facility ' s undated policy titled, Maintenance Service, revised in 12/2009, indicated that maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy included the functions of the maintenance personnel that include, but are not limited to: 1. Maintaining the building in compliance with current federal, state, local laws, regulations, and guidelines. 2. Maintaining the building in good repair and free from hazards. 47467 3. A review of Resident 135's Admission Record indicated Resident 135 was admitted to the facility on [DATE] with diagnosis that included anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), and schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) A review of Resident 135 ' s Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 5/1/2024 indicated, Resident 135 was cognitively intact (able to think, remember, and reason), able to walk at least 150 feet (unit of length) in a corridor or similar space, and was independent (no help or staff oversight at any time) in toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). During an interview on 6/26/2024 at 10:14 AM with Resident 135, Resident 135 stated there had been no paper towel in the restroom for at least three months. Resident 135 stated, he felt that it was very uncomfortable after washing his hands with nothing to dry them. Resident 135 stated, he felt upset and dirty leaving his hands wet. During an observation on 6/26/2024 at 11:08 AM in Resident 135 ' s room, the paper towel dispenser was observed broken with no paper towel to use after washing their hands. During an interview on 6/27/2024 at 3:54 PM with the Maintenance Supervisor (MS), the MS stated, the paper towel was the housekeeping responsibility. The MS stated, when the housekeeper cleaned the restrooms, they should have checked and reported to him so he could get the paper towel dispenser fixed. The MS stated no one had reported the broken paper towel dispenser to him in the last three months. The MS stated, the paper towel should not be out for months because it was not good for the resident. The MS stated, with no paper towel, the residents might not want to wash their hands and infection could happen. The MS added, the resident could get angry after washing his hands and when they found out that there was no paper towel to dry them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/28/24 at 8:45 AM with Housekeeper (HK) 1 in Resident 135 ' s restroom, the paper towel dispenser was observed broken, HK 1 stated he noticed the paper towel has been empty since the previous week, but he was not able to refill it because the paper dispenser was broken. HK 1 stated, he did not report the issue to his supervisor. A review of the facility ' s policy and procedure (P&P) titled, Quality of Life - Homelike Environment, revised May 2017, indicated residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, which include clean bed and bath linens that are in good condition. A review of the facility ' s P&P titled, Housekeeping Procedure, revised May 2017, indicated bathroom cleaning included to fill dispensers ' soap and paper 47882 4. During a concurrent observation and interview on 6/26/2024 at 4:05 PM with maintenance assistant (MA) in BDA room, the MA stated, the room felt a little warm with 3 small window type air conditioning and one cooler, room temperature was 81.6 degrees F upon temperature check via infrared thermometer (use to determine the surface temperature). MA stated, B1 was an old building, and the air-conditioning are old. MA stated, he would add a portable cooler. During an interview on 6/26/2024 at 4:10 PM with Program Manager (PM) 1, PM 1 stated, this BDA room gets hot, and it can affect the health and behavior of all 27 residents that comes here for meals and activities. During an interview on 6/26/2024 at 4:15 PM with Program Director (PD), PD stated, this BDA room gets warm during summer and can affect resident ' s behavior during meals and activities. A review of Residents 99 Admission Record (AR), dated 6/27/2024, the AR indicated Resident 99 had diagnoses that included schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations), major depressive disorder (persistent feeling of sadness and loss of interest), and hypertension (high or raised blood pressure). A review of Residents 99 history and physical (H&P), dated 3/18/2024, the H&P indicated Resident 99 was alert and oriented x 3 (normal level of orientation). A review of Resident 99 ' s Minimum Data Set (MDS- a standardized assessment and screening tool), dated 6/13/2024 indicated Resident 99 was independent with walking and toileting, and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and or contact guar assistance as resident completes activity) with personal hygiene and eating. During a concurrent observation and interview on 6/26/2024 at 4:20 PM with Resident 99 in BDA room, Resident 99 wearing tank top and with a sweaty forehead. Resident 99 stated, he goes to the BDA room for meals and activities daily and it gets hot and uncomfortable and wished it would be better. A review of Residents 101 Admission Record (AR), dated 6/27/2024, the AR indicated Resident 101 had diagnoses that included schizoaffective disorder, major depressive disorder, and hypertension. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Residents 101 history and physical (H&P), dated 9/6/2023, the H&P indicated Resident 101 was alert and oriented x 3 (normal level of orientation). A review of Resident 101 ' s Minimum Data Set (MDS- a standardized assessment and screening tool), dated 6/10/2024, indicated Resident 101 was independent with eating, walking, and toileting, and required supervision with personal hygiene. During a concurrent observation and interview on 6/26/2024 at 4:25 PM with Resident 101 in BDA room, Resident 101 wearing a black shirt with sweaty forehead. Resident 101 stated, it gets hot, and it makes him uncomfortable and would like to have a better air-conditioning system. A review of Residents 106 Admission Record (AR), dated 6/27/2024, the AR indicated Resident 106 had diagnoses that included schizoaffective disorder, major depressive disorder, and paranoid schizophrenia (It affects how you think and behave). A review of Residents 106 history and physical (H&P), dated 4/22/2024, the H&P indicated Resident 99 was alert and oriented x 3 (normal level of orientation). A review of Resident 106 ' s Minimum Data Set (MDS- a standardized assessment and screening tool), dated 5/3/2024, indicated Resident 106 was independent with eating, toileting, personal hygiene, and walking. During a concurrent observation and interview on 6/26/2024 at 4:30 PM with Resident 106 in BDA room, Resident 106 wearing a tank top with sweaty forehead. Resident 106 stated, it gets overwhelmingly hot, and it makes him uncomfortable and wished the facility would do something about the air-conditioning system. During an interview on 6/27/2024 at 8:35 AM with the DON, DON stated, she already talked to the maintenance about the hot temperature in the BDA room in the Bungalow building. DON stated it is important for the facility to maintain rooms in a safe and comfortable levels because if it ' s hot it can negatively affect the health and the mood of the residents. A review of the facility ' s policy and procedure (P&P) titled, Environment - Temperatures - Test & Log Air Temperatures, (undated), indicated, all buildings are required to maintain an ambient temperature throughout resident and patient areas in a temperature range of 71 to 81 degrees F or at more restrictive range required by state or local requirements. Exceptions to this range may be available for brief periods of unseasonably warm or cold temperatures; however, the variance must not adversely affect resident or patient health and safety.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview, and record review, the facility failed to develop a comprehensive, resident-centered care plan and implement plan of care for one of three sampled resident (Resident 41) who was at risk for falls and incidents of fall during smoke breaks and showering. This had failure resulted in Resident 41 not receiving the appropriate interventions to prevent recurrent falls that resulted in minor injuries. Findings: A review of Resident 41's Admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (mental illness that include hallucinations [false perceptions of reality such as hearing voices or seeing images that are not real] and/or delusions [fixed, false beliefs that conflict with reality]) and unspecified schizoaffective disorder (a mix of schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] symptoms such as hallucinations and delusions and mood disorder symptoms). A review of Resident 41's Minimum Dat Set (MDS-a comprehensive assessment and care screening tool) dated 5/20/2024, indicated Resident 41 had moderate cognitive impairment, had inattention (difficulty focusing attention), required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) with eating, oral and personal hygiene and had falls since admission with injury. A review of Resident 41's Post-Fall Review, dated 10/2/2022 indicated, Resident 41 was observed by staff walking fast after smoke break and lost balance, fell on the cement and sustained abrasion to the left side of his face and right knee. Interdisciplinary Team (IDT) notes indicated resident needed constant reminder from staff not to walk fast so he does not lose balance and fall again. A review of the Resident 41's clinical record indicated no evidence that a care plan was developed for the resident fall that occurred on 10/2/2022. A review of Resident 41's Change in Condition (COC) Notes, dated 10/02/2022 indicated resident fell , sustained abrasions to left cheek and knees and left big toe, primary physician and health care agent were notified, resident was placed on neuro check (exam to check mental status, coordination, ability to walk and how well the muscles, sensory systems and deep tendon reflexes work) and treatment orders for the injuries. A review of Resident 41's Post-Fall Review, dated 12/2/2022, indicated Resident 41 self reported a fall incident that while in the shower room resident fell . IDT (Interdisciplinary Team- a team that develops a plan of care for the residents) notes stated to counsel Resident 41 to call for help as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 41's care plan initiated on 12/2/2022 indicated resident was at risk for harm during ADLS (activities of daily living). To reduce the risk for self harm during ADLs, the facility will instruct the resident to call for additional staff for support when needed, will supervise/oversight with resident during showering and personal hygiene. A review of Resident 41's Change in Condition notes dated 12/02/2022 indicated a fall that caused small cut to the left eyebrow while in the shower. Resident 41 was placed on neuro check for seventy-two hours and treatment to the left eyebrow. A review of Resident 41's Post-Fall Review, dated 3/8/2024, indicated a witnessed fall, resident running up the ramp, tripped and fell on to his left cheek and knees. IDT notes stated redness and swelling to his left cheek without a fracture. IDT notes indicated verbal counseling and education was provided to Resident 41 to prevent future falls. A review of Resident 41's Change in Condition Notes, dated 3/8/2024 indicated Resident 41 had unstable gait and balance, was on antipsychotic medications that can contribute to risk for falls, sustained redness and swelling to the left cheek, placed on neuro check for seventy-two hours and continued to monitor for safety. A review of Resident 41's care plan initiated on 3/8/2024 indicated resident had a witnessed fall after smoke break at the backyard. The care plan goal indicated to ensure Resident 41 will have no signs and symptoms of neurologic deficit (brain dysfunctions) and will have no complications due to fall, the facility will place the resident on 72-hour neuro check, place on every 15 minutes monitoring for safety for seventy-two hours and one to one counseling. During a concurrent observation and interview at 6/25/24 at 11:12 AM with Resident 41 inside his room, Resident 41 was observed well groomed and fixing his belongings at the bedside. Resident 41 stated he remembered falling but does not recall if there was staff during the falls. During an interview on 6/26/24 at 3:08 PM with Certified Nursing Assistant (CNA) 5, CNA 5 stated she was not aware Resident 41 was at risk for fall. CNA 5 stated Resident 41 tripped and fell in the patio before, and CNA 5 stated she does not recall any monitoring for fall risk before the fall incident. CNA 5 stated it was important to report to the charge nurse any falls or accidents incidents right away, endorse to the next shift and document the incident in the residents' clinical record to ensure incident does not happen again. During an interview on 6/26/24 at 3:27 PM with Program Counselor (PC) 1, PC 1 stated he was not aware of any supervision Resident 41 needed, for resident with history off falls and risk for accidents, or injury. During a concurrent interview and record review on 6/26/24 at 3:47 PM with Licensed Vocational Nurse (LVN) 10, Resident 41's Progress Notes and Fall Risk Assessments were reviewed. LVN 10 stated Resident 41 was high risk for fall, and last fall incident was on 3/8/24. LVN 10 stated Resident 41's Progress Notes and Medication. Administration Record (MAR) indicated he was not monitored for falls after the incident. LVN 10 stated it was important that fall incidents were endorsed each shift to prevent further falls, create or revise care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/24 at 3:57 PM with LVN 7, Resident 41's Progress Notes were reviewed which indicated the following fall incidents: 1. On 10/2/2022, after smoke break, Resident 41 was walking up the ramp rapidly and fell which resulted in abrasion to the left side of his face and right knee. LVN 7 stated there was no comprehensive care plan developed to address resident's behavior of running and walking fast while in the smoking area- ramp. 2. On 12/2/2022 while in the shower, Resident 41 reported he had unwitnessed fall that resulted in minor injury. 3. Resident 41 fell on [DATE]. LVN 7 stated Resident 41's care plan did not identify specific intervention to address resident falls related to running or walking fast in the ramp during the smoke break. During a continued concurrent interview and record review on 6/26/24 at 3:57 PM with LVN 7, stated on 3/8/24, Resident 41 was supposed to be placed on every 15 minutes monitoring for 72 hours. LVN 7 stated there was no documented evidence in the Resident 41's clinical record that interventions were implemented to prevent recurrent fall of the resident. A concurrent interview and record review on 06/28/2024 at 10:10 AM with the Director of Nursing (DON), the care plan, fall risk assessments, post fall review and policies on baseline and comprehensive person-centered care plans were reviewed. DON stated Resident 41 had no safety awareness, that was the reason why the resident needed supervision. DON stated Resident 41 had fallen 2-3 times, the interventions according to the care plan dated 2/12/2022 indicated supervise/oversight during showering, however there was no documented evidence that the resident was supervised when showering and care plan was not updated. DON also stated Resident 41 fell on [DATE] while walking fast. The DON stated there was no care plan in resident's clinical record that addressed intervention to prevent fall for resident's behavior of walking/running fast in the smoking area. The DON further stated that it is important to know if resident was a fall risk to know why a resident kept falling and what conditions contribute to falls so falls can be prevented. A review of the facility's Policy titled Care Plans - Baseline, revised March 2022 stated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Care Plan, Comprehensive Person-Centered, revised March 2022, stated 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 IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; is developed within seven days of the completion of the required MDS assessment (Admission, Annual or Significant Change in status).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 36925 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 85) received treatment and care according to the physician`s order by failing to cover Resident 85 ' s wound on his right arm with wound dressing for five (5) days. This deficient practice had the potential to expose Resident 85 to infection that could worsen the condition of the wound. Findings: A review of Resident 85 ' s Admission Record indicated that the facility admitted the resident on 09/10/2016 with diagnoses that included schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression). A review of Resident 85 ' s Minimum Data Set (MDS - a standardized assessment and screening tool), dated 06/11/2024, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired but he was able to perform his daily living activities independently. A review of Resident 85 ' s Change in Condition, dated 06/23/2024, indicated that Resident 85 had an altercation with another resident which resulted in Resident 85 sustaining superficial skin scratch on his right upper arm with minimal bleeding. A review of Resident 85 ' s Physician ' s Order, dated 06/23/2024 at 10 PM, indicated an order to clean Resident 85 ' s right arm with warm soap and water, rinse with normal saline (a mixture of water and salt[sodium chloride] solution, pat dry, apply A&D ointment, and to cover with a dry dressing daily for five (5) days. During a concurrent observation and interview on 06/25/2024 at 10:10 AM with Resident 85, Resident 85 stated he was recently involved in a physical altercation with another resident on 6/23/24 (two days ago) which resulted in a superficial scratch to his right arm. During the interview, Resident 85 ' s right arm was observed with a scratch (approximately three inches long) that was open to air with no wound dressing. During a follow-up interview with Resident 85 on 06/26/2024 at 2:47 PM, Resident 85 stated that a nurse applied alcohol and a wound dressing to his right arm wound after a physical altercation with another resident on 6/23/24. Resident 85 stated since the dressing came off during a shower, the nurse had not replaced the wound dressing since 6/23/24 (three days ago). During an interview with licensed vocational nurse (LVN) 1 on 06/26/2024 at 4:04 PM, LVN 1 stated not covering Residents 85 ' s right arm wound with a dressing because she did not read the physician ' s orders in its entirety, indicating to apply a dressing. LVN 1 stated, Not following a wound treatment order according to instructions could expose the resident to infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 06/26/2024 at 4:13 PM, the DON stated licensed nurse must follow and carry out all physician orders. The DON stated when physician's orders were not followed properly, there was a potential to expose the resident to infections, which could cause further deterioration of the wound. A review of the facility ' s policy titled, Medication Administration - General Guidelines, dated 10/2017, indicated that medications are administered as prescribed in accordance with good nursing principles and practices.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49537 Based on observation, interview and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily and was not posted in a prominent location readily accessible to residents and visitors for viewing in accordance with the facility ' s policy and procedure titled Posting Direct Care Daily Staffing Numbers. This deficient practice resulted in inaccessibility of the accurate daily number of clinical staff giving direct care to the residents. Findings: During an observation on 06/25/2024 at 08:26 at the reception area in the front lobby, the Census and Nursing Hours per Patient Day (NHPPD-form indicating projected and actual daily nursing hours), dated 06/23/2024 and 06/24/2024 were observed posted by the reception area indicating the beginning patient census for the day was 147. The posted NHPPD dated 06/23/2024 had not been signed by the Director or Nursing or Designee. During an observation on 06/25/2024 at 09:06 AM, there were no NHPPD forms posted in Nursing Stations 1 and 2. During another observation on 06/25/24 at 09:15 AM in the reception area in the front lobby, the NHPPD dated 06/24/24 was incomplete, since it was missing the Actual Hours for the Scheduled Total Direct Care Service Hours and Actual Total CNA direct care hours, and the Director of Nursing (DON)/ designees had not signed the DHPPD. During an interview on 06/25/2024 at 09:15 with the Director of Staff Development (DSD), DSD stated he was responsible for completing the projected hours and posting the form in the reception area. The DSD stated the Payroll Coordinator (PRC) was responsible for computing the actual hours and posting the form in the reception area. During a concurrent interview and record review on 06/26/24 at 02:39 PM with DSD, the NHPPD form dated 6/24/24 and 6/25/24 were reviewed. The DSD stated the actual hours were not completed, visibly posted, and signed by the DON within two hours of the beginning of the shift. The DSD also stated that licensed staff were under the scheduled total direct care hours, however, the DSD stated he did not specify registered nurse (RN) or licensed vocational nurse (LVN) on the NHPPD, as indicated per the facility ' s policy and procedure. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/24 at 2:56 PM with PRC, records titled, NHPPD dated 6/23/24 and 6/24/24 were reviewed. The PRC stated the DSD visibly post the NHPPD projected hours form, every morning before 8:45 AM. The PRC stated the actual hours were calculated by the PRC, and the visibly posted the NHPPD form before 8:45 AM, every morning and then present the NHPPD during the daily meeting. The PRC also stated the purpose of the form was to ensure there was sufficient amount of direct care staffing to care for all residents in the facility. The PRC stated since she had not posted the NHPPD actual hours, residents did not have access to the Direct Care Daily staffing numbers. During a concurrent interview and record review on 06/28/24 at 10:00 AM with the Director of Nursing (DON), NHPPD forms dated 6/23/24 and 6/24/24 were reviewed. The DON stated the NHPPD forms were reviewed and signed by the DON daily and checked for accuracy. A review of the facility ' s policy, titled Posting Direct Care Daily Staffing Numbers, revised August 2022, indicated within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The information recorded on the form shall include the following: the resident census at the beginning of the shift for which the information is posted; the twenty-four-hour shift schedule operated by the facility; the shift for which the information is posted; type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift; the actual time worked during that shift for each category and type of nursing staff; and total number of licensed and non-licensed nursing staff working for the posted shift. The policy also indicated: Within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct staff and completes the Nurse Staffing Information for. The charge nurse completes the form and posts the staffing information in the location designated by the administrator.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review the facility failed to ensure that licensed nurses administered medications in accordance with the facility ' s policy and procedure for one of six sampled residents (Resident 80). Resident 80 documented on the electronic medication administration record (eMAR) that MiraLAX (a medication used to treat constipation-lack of bowel movement) was administered to the resident at 9AM dose on 6/26/24, but Licensed Vocational Nurse (LVN) 1 observed omitting the MiraLax during the medication pass observation. This deficient practice had the potential for Resident 80 ' s medication to be omitted contributing to medication error and/or decline in health condition/illness. Findings: A review of Resident 80's Admission Record indicated resident 80 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a disorder that affect a person ' s ability to think, feel, and behave clearly.) and depression (a common and serious medical illness that negatively affects how the person feels, the way they think and how they act). A review of Resident 80's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 04/01/2024, indicated resident 80' s cognitive (relating to the process of acquiring knowledge and understanding) and decision-making skills were intact. Resident 80 required supervision (oversight, encouragement, or cueing) with activities of daily living, such as eating, oral hygiene, and personal hygiene. A review of Resident 80's Physician Order dated 07/03/2024, indicated an order for Miralax (medication used to treat occasional constipation oral powder 17grams (gm, a unit of measurement of mass)/scoop, give 17 gm by mouth (PO) one time a day for bowel trouble (hold for loose stool) administer with 8 ounce (oz, a unit of measurement of mass) at 9AM. During a medication administration observation, on 6/26/2024 at 8:30 AM, Resident 80 was observed in line waiting to receive medications, while licensed vocational nurse (LVN)1 was observed preparing medications for administration inside nursing station (NS) 1. LVN 1 was observed omitting the medication administration of MiraLAX to Resident 80, however she stated documenting MiraLAX was administered to Resident 80 on the electronic medication administration record on 6/26/24 for the 9AM dose. During a concurrent observation and interview on 06/26/23 at 9:41 AM with LVN 1, medication reconciliation (the process of comparing a patient's medication orders to all of the medications that the patient has been taking) for Resident 80 was observed. LVN1 stated she did not administer MiraLAX to Resident 80, however documented on the electronic medication administration record (eMAR) that MiraLAX was administered for 9AM dose on 6/26/24. LVN 1 stated that she was supposed to give medications then document that it was given to prevent risk of medication errors. The LVN 1 further stated it was important to ensure that residents did not miss their medications and receive them according to physician's orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 20 ' s eMAR dated 6/1/24 to 6/30/24, indicated LVN 1 documented administering Miralax to Resident 80 on 6/26/24 at 9AM. During an interview with the Director of Nursing (DON), on 06/26/2024 at 10:02 AM, the DON stated medication administration must be documented after licensed nurse administer the medication, and not before to prevent medication errors. The DON stated there were protocols that facility must follow to ensure residents receive their medications as ordered and as prescribed by the physician. A review of the facility ' s policy and procedure titled, Medication Administration-General Guidelines, dated 10/2017, indicated that medications are administered in accordance with written orders of the attending physician. The policy indicated administration of the medication dose was documented on the MAR directly after the medication is given.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882 Based on observation and interview and record review the facility failed to implement the policy and procedure on food storage, in accordance with professional standards of practice for food service safety by failing to: 1.Label and date two brown bags of fruits with approximately 20 oranges and six apples. 2.Label and date six head of lettuce in a clear plastic container. 3.discard an open box of cinnamon rolls with an expired used by date of [DATE]. These deficient practices had the potential to result in food contamination, growth of microorganisms (disease causing organism) that could cause foodborne illness (food poisoning or food illness due to pathogens (harmful organism that cause illness such as bacteria, viruses, or parasites) and toxins that contaminate food and negatively affect the health of the residents who consumed it. Findings: During an initial kitchen tour observation and concurrent interview on [DATE] at 8:40 AM with the Dietary Service Supervisor (DSS) during a tour, observed: a) two brown bags of fruits in the refrigerator with approximately 20 oranges and six apples without a label or a used by date. b) six heads of lettuces in a clear plastic container in the walk-in refrigerator without a label or a used by date. c) an open box of 15 frozen cinnamon rolls in the freezer with an expired used by date of [DATE]. In an interview on [DATE] at 8:40 AM, the DSS stated, the food in the kitchen should be labeled with used by and expired date or food should be discarded immediately. DDS stated, not having label on the food and/or having an expired used by date foods, had the potential for the old food to be contaminated and could cause foodborne illness for residents who consumed it. During an interview on [DATE] at 9AM with Dietary Aid (DA) 1, DA1 stated, labeling of food was important so they would know when it was delivered and when the food could be used by. DA 1 stated, expired food should have been discarded immediately to prevent contamination of other food in the food storage. DA 1 stated, he was not sure why the expired foods were not discarded, and some foods are not labeled with a used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:45 PM with the Director of Nurses (DON), DON stated, the kitchen staff should ensure that all expired foods are discarded immediately, and everything else should be labeled and dated with a used by date. DON stated, it is important to follow these practices because, if not, it can cause food contamination, and cause food borne illnesses that can affect residents ' health. A review of the facility ' s policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, indicated, all food items in the storeroom, refrigerator, freezer need to be labeled and dated based on established procedures for either food safety or product rotation (FIFO- First In - First Out). The P&P indicated, the Use By date will be the absolute date in which the food must be consumed or discarded by the facility. A review of the Food Code 2022, indicated ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Indicated READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47882 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse (food waste, scraps) properly by not covering two of three metal dumpsters (large trash container designed to be emptied into a truck) and leaving more than 15 old mattresses and a broken sofa by the garbage area. This deficient practice had a potential to attract birds, flies, insects, pest and rodents that could spread infection to residents and staffs in the facility. Findings: During a concurrent observation and interview on 6/26/2024 at 11:30 AM with Dietary Service Supervisor (DSS) in the facility's garbage area, observed two of three metal dumpsters were not covered, and 15 old used mattresses and a broken sofa were nearby the garbage area next to the garbage bins. DSS stated, it was concerning to see the garbage area like this, which could lead to infestation of rodents, insects, and other pest that can cause spread of infection that could affect, everyone, staffs, and residents. During an interview on 6/26/2024 at 11:50 AM with Dietary Aid (DA) 2, DA 2 stated, he was one on the dietary team that takes trash to the metal dumpsters and said the metal dumpster lids need to be close all the time, because it could attract rats, birds and other insects and it is bad for everyone. During an interview on 6/26/2024 at 12:10 PM with Maintenance Supervisor (MS), MS stated, keeping garbage area clean is everyone ' s responsibility, metal dumpster lids should be kept closed. MS stated, the garbage could harbor rats and insects. During an interview on 6/26/2024 at 3:30 PM with the Administrator (ADM), ADM stated, she will address the trash in the garbage area immediately because it was potential for pest and other insects' infestation and can affect the residents and staff ' s health. During an interview on 6/26/2024 at 3:45 PM with the Director of Nurses (DON), DON stated, she expects the dumpster bin lids are kept close and not overflowing, and the garbage area clear of any other trash such as old mattresses and furniture. DON stated, the garbage and refuse can harbor pest, flies and rodents and it could negatively affect residents ' and staff ' s health. A review of the facility ' s policies and procedures (P&P) titled Food-Related Garbage and Rubbish Disposal, (Undated), indicated: a) all garbage and rubbish containing food waste shall be kept in containers, b) All garbage and rubbish containers shall be provided with tight fitting lids or covers and must be kept covered, c) Garbage and food waste containing food waste will be stored in a manner that is inaccessible to vermin, d) outside dumpster provided by garbage pickup services will be kept close and free of surrounding litter and, e) Tr ash, garbage is not to be filled above the full line, nor is it to be scattered on the ground.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview, and record review, the facility failed implement the facility ' s policy and procedure on infection control by failing to ensure the facility monitor ' s its water system to ensure the water was free of legionella (bacteria most found in water, including groundwater, fresh and [NAME] surface waters that causes severe pneumonia [severe infection in the lungs]. Legionella is transmitted through breathing in Legionella-contaminated, aerosolized [the form of a fine spray] water and is also possible from breathing in Legionella contaminated soil or while drinking water) as evidenced by not conducting water testing for legionella. This deficient practice had the potential to result in the infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and a widespread infection in the facility. Findings: During an interview on 6/27/24 at 3:00 PM, with the Infection Preventionist (IP), the IP stated the facility did not test the water system for legionella. The IP stated the maintenance personnel ran the water every week and checked water temperature daily to prevent the growth of legionella. The IP stated the facility had not had any legionella case and they would call the regional consultant if there was any suspicious legionella case in the facility. The IP stated she would not know if the facility ' s water system had legionella without testing for it. The IP stated the facility should test water for legionella to prevent potential spread of legionella to ensure residents ' safety. During an interview on 6/27/24 at 3:50 PM, with the Maintenance Supervisor (MS), the MS stated he would not know if there was any growth of legionella in the facility water system because they never tested it. The MS stated not testing the water system for legionella put the residents at risk for potential exposure to legionella and related illness. During a telephone interview on 6/27/24 at 4:19 PM, with the Administrator (ADM), the ADM stated the facility does not conduct regular legionella testing. The ADM stated the facility only conduct legionella test when it was suspicious, and the facility had not done any test recently. During a review of the facility ' s policy and procedure (P&P) titled, Legionella Water Management Program, revised on 9/22, indicated the water management program included A system to monitor control limits and the effectiveness of control measures. During a review of Centers for Clinical Standards and Quality/Quality, Safety and Oversight Group (QSO)-17-30: Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires ' Disease (LD), dated 6/2/17, indicated Facilities must have water management plans and documentation that, at a minimum, ensure each facility: .specifies testing protocols and acceptable ranges for control measures, and document the results of testing .

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to ensure the bed frames, mattresses and bedrails were checked for compatibility and size prior to use and the staff, routinely inspects all beds and related equipment to identify risks and problems including potential risk for entrapment (trapped or entangled in the spaces in or about the bed rail, mattress or hospital bed frame) for four of thirty residents (Residents 15, 67, 108, 109) who were observed with 6 to 10 inches gaps between the mattress and footboard. This deficient practice had Residents 15, 67, 108, 109 to have their arms, legs, foot, and head to entrap between the bed mattress and foot board and result in injury and death. Findings: 1. A review of Resident 15 ' s Admission Record indicated Resident 15 was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia [mental illness that included hallucinations (false perceptions of reality, such as hearing voices or seeing images that aren't real) and/or delusions (fixed, false beliefs that conflict with reality)], type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), anxiety disorder (a group of mental disorders characterized by significant feelings of fear that affect with daily activities), and nightmare disorder (a pattern of repeated frightening and vivid dreams that affects quality of life). A review of Resident 15 ' s Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 5/15/2024, indicated Resident 15 was cognitively intact (able to think, remember, and reason), and needed supervision (oversight, encouragement, or cueing) in eating, oral and personal hygiene. 2. A review of Resident 67 ' s Admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia, type 2 diabetes mellitus, and anxiety disorder. A review of Resident 67 ' s, an MDS, dated [DATE], indicated Resident 67 was moderately impaired, needed supervision in eating, oral and personal hygiene. 3. A review of Resident 108 ' s Admission Record indicated Resident 108 was admitted to the facility on [DATE] with diagnosis that included hypertension (high blood pressure), type 2 diabetes mellitus, obesity (a condition which the body has too much fat), schizoaffective disorder (mental illness that affects mood and has symptoms of hallucinations and/or delusions), and Covid-19. A review of an MDS, dated [DATE], indicated Resident 108 was cognitively intact, needed supervision in eating, oral and personal hygiene. 4. A review of Resident 109 ' s Admission Record indicated Resident 109 was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia, and anxiety disorder. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 109 ' s, an MDS, dated [DATE], indicated Resident 109 was moderately intact, and needed supervision in eating, oral and personal hygiene. During a concurrent observation and interview on 6/25/2024 at 10:34 AM, Resident 109 was observed sleeping with her head at the end of the bed, just below a wide gap between the mattress and the footboard. During an observation on 6/26/2024 at 11:15 AM with the Maintenance Supervisor (MS) to measure the gap between the residents ' mattress and the bed frames in six sampled resident ' s rooms, fifteen (15) residents ' beds including Resident 15 [10 inches (units of length)], Resident 67 (9 inches), Resident 108 (10 inches), and Resident 109 (6 inches) were measured with at least five (5) inches between the mattress and the resident ' s footboard. During an interview on 6/26/2024 at 11:30 AM with the MS, the MS stated, he had been working in the facility for a few years and noticed that the mattresses looked too small and were not compatible to the bed frames. The MS stated the gap between the resident ' s mattress and the footboard had been wide since he started working in the facility, but he did not know that it was not safe for the residents to sleep in. The MS stated the wide gap between the mattress and the bed frame could cause a potential risk for bed entrapment. During an interview on 6/28/2024 at 3:23 PM with the Maintenance Assistant (MA) 2, MA 2 stated, the new mattresses were stored in the storage room, and they were all the same size. MA 2 stated, the residents ' mattresses were way smaller than the bed frame, which caused a large gap between the mattresses and the footboards. MA 2 stated, the residents could be at risk for entrapment due to the wide gap. MA 2 stated, when he replaced the resident ' s mattresses, with the new mattresses in the storage room were the same size as the old one so he did not report his concern to the Administrator because he thought it was normal to have a wide gap. During an interview on 6/28/2024 at 3:34 PM with the Administrator designee (ADM 1), ADM 1 stated, he believed the mattresses should be at least 80 inches in length to fit in the existing residents ' bed frames. ADM 1 stated, the mattresses were too small, about 73 inches in length, which cause the wide gap between the mattresses and the footboards. The ADM 1 confirmed that there was a potential risk for bed entrapment and the residents could be at risk for injuries. A review of the facility ' s policy and procedure (P&P) titled, Bed Safety and Bed Rails, revised August 2022, indicated: -Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. -Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident ' s head or body. Any gaps in the bed system are within the safety dimensions established by the FDA (US Food & Drug Administration). -Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the document titled, Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/2006, indicated that the FDA recognizes the space between the inside surface of the headboard or foot board and the end of the mattress, as an area for risk of entrapment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to maintain a safe and sanitary environment as indicated in the facilitys policy and procedure for five of thirty sampled residents by failing to 1. Ensure Residents 29, 80 and 100's room were free of flies. 2. Ensure Resident 26 had a clean pillow and without stain. 3. Ensure Resident 108 with verrucous lesion (raised growth on the surface of the skin) to left elbow, was provided with safe, sanitary environment without flies and gnat (commonly known as fruits flies are small black winged insects). This failure had a potential to result for residents to be at risk for food and drink contamination, including a risk for the residents to have wound infection when exposed to flies and lead to the spread of infection in the facility. These deficient practices had the potential to result in residents ' discomfort and the spread of infection. Findings: 1a. During a review of Resident 29 ' s Admission Record indicated the facility admitted Resident 29 on 12/16/11 with diagnoses that included schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly) and hypertension (high blood pressure). During a review of Resident 29 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/31/24, indicated Resident 29 had moderately impaired memory and cognition (ability to think and reasonably). The MDS indicated Resident 29 required supervision and touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene, and independent with toileting hygiene, chair/bed-to-chair transfer, and toilet transfer. During a concurrent observation and interview on 6/25/24 at 10:31 AM, in Resident 29 ' s room, with Certified Nursing Assistant (CNA) 2, black small flies were flying in room. CNA 2 swung her right hand and tried to catch the fly. CNA 2 stated the fly looked like a fruit fly. CNA 2 stated she saw flies in the hallway and residents ' rooms since yesterday. CNA 2 stated the fruit flies might have come in with the fruits when residents brought fruits inside their room. CNA 2 stated the facility should not have flies inside the building to ensure residents ' comfort and prevent spread of infection. 1b. During a review of Resident 100 ' s Admission Record indicated the facility admitted Resident 100 on 3/11/20 with diagnoses that included schizophrenia and hypotension (low blood pressure). (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 100 ' s MDS, dated [DATE], indicated Resident 100 had intact memory and cognition. The MDS indicated Resident 100 required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene, and was independent with toileting hygiene, sit to stand, chair/bed-to-chair transfer and walk 150 feet. During a concurrent observation and interview on 6/25/24 at 10:50 AM, in Resident 100 ' s room, a fly was on the left side of Resident 100 ' s curtain. Resident 100 pointed at the fly and stated there was a fly on the curtain. Resident 100 stated he sees flies in his room every day which makes him feel uncomfortable. Resident 100 stated he was afraid of getting infection from these flies. 1c. During a review of Resident 80 ' s Admission Record indicated the facility admitted Resident 80 on 12/22/23 with diagnoses that included schizophrenia and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 80 ' s MDS, dated [DATE], indicated Resident 80 had intact memory and cognition. The MDS indicated Resident 80 required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene, and was independent with toileting hygiene, sit to stand, chair/bed-to-chair transfer and walk 150 feet. During an interview on 6/25/24 at 11:53 AM, with Resident 80, Resident 80 stated he started to see flies inside the building, such as residents ' rooms, hallways, and shower rooms, about 1 month ago. Resident 80 stated some residents took food into their rooms, resulting flies inside the building. Resident 80 stated the flies made him feel uncomfortable and he was afraid of getting sick from the flies. 2. During a review of Resident 26 ' s Admission Record indicated the facility originally admitted Resident 26 on 7/21/11 and readmitted Resident 26 on 3/21/24, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and type II diabetes mellitus (a disease of inadequate control of blood levels of glucose [blood sugar]). During a review of Resident 26 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/31/24, indicated Resident 26 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 26 required supervision or touching assistance with eating, oral hygiene, shower/bathe self, and personal hygiene, and was independent with toileting hygiene, sit to stand, chair/bed-to-chair transfer and walk 150 feet. During a concurrent observation and interview on 6/25/24 at 10:55 AM, with Licensed Vocational Nurse (LVN) 4, Resident 26 ' s white wedge pillow on the bed had with brown and red stains. LVN 4 stated the brown and red stains on the white wedge pillow looked like old stains and she did not know how long the stains were on the pillow. LVN 4 stated if the resident did not complain about the stains and the staff did not need to wash or remove the stains. LVN 4 stated she does not when the pillow was last washed and cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/25/24 at 3:10 PM, in Resident 26 ' s room, with Resident 26, was again observed with white wedge pillow on the bed had with brown and red stains. Resident 26 stated he used the wedge pillow as a pillow to sleep and the stains was probably from his drools when he was sleeping. Resident 26 stated the pillows he uses were the same pillows since he was admitted to the facility, Resident 26 stated he never saw the staff take the pillow to wash or clean, and he did not know when the last time the staff washed or cleaned it. Resident 26 stated he did not know that he could request the staff to clean it or change it. Resident 26 stated he would like to sleep on a clean pillow for his comfort. During a concurrent observation and interview on 6/25/24 at 3:18 PM, in Resident 26 ' s room, with CNA 1, observed a white wedge pillow with brown and red stains was on Resident 26 ' s bed. CNA 1 stated she would take this pillow to the laundry and had it cleaned. CNA 1 stated if the stains were not removable, she would replace it with a clean pillow since it was not Resident 26 ' s person item. CNA 1 stated Resident 26 should not use the dirty pillow. During a concurrent interview and record review on 6/26/24 at 2:46 PM, with the Laundry Personnel (LP), the picture of Resident 26 ' s wedge pillow, taken on 2/25/24, was observed. The LP stated Resident 26 ' s wedge pillow was dirty with brown and red stains and the staff should have brought the pillow to the laundry room to be wash and clean. The LP stated if they could not remove the stains, they would not return the dirty pillow to Resident 26, instead, they would provide Resident 26 with a new pillow. The LP stated Resident 26 should not continue to use the dirty pillow because it was not sanitary and comfortable for the resident. During an interview on 6/28/24 at 2:17 PM, with the Director of Nursing (DON), the DON stated she went to check Resident 26 ' s pillow and the pillow should be washed. The DON stated if the stains on the pillow was not removable, the staff should replace it with a new pillow. The DON stated Resident 26 should not use a dirty pillow like that for the resident ' s comfort and the facility should provide Resident 26 with a sanitary environment. During a review of the facility ' s policy and procedure titled, Quality of Life-Homelike Environment, revised 5/17, indicated the facility staff and management shall provide a clean, sanitary and comfortable environment to the residents. 47467 3. A review of Resident 108 ' s Admission Record indicated Resident 108 was admitted to the facility on [DATE] with diagnosis that included hypertension (high blood pressure), type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), obesity (a condition which the body has too much fat), schizoaffective disorder [mental illness that affects mood and has symptoms of hallucinations (false perceptions of reality, such as hearing voices or seeing images that aren't real) and/or delusions (fixed, false beliefs that conflict with reality)], and Covid-19. A review of Resident 108 ' s Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 3/31/2024, indicated Resident 108 was cognitively intact (able to think, remember, and reason), able to walk at least 150 feet (unit of length) in a corridor or similar space, needed supervision (oversight, encouragement or cueing) in eating, oral and personal hygiene, and was independent (no help or staff oversight at any time) in toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 108 ' s Care plan, dated 4/12/2024, indicated Resident 108 was at risk for impaired skin integrity related to verrucous lesion to left elbow, and the interventions included to educate resident to maintain proper hygiene. During an observation on 6/25/2024 at 11:10 AM in Resident 108 ' s room, one banana peel was observed on the floor while Resident 108 was sleeping on the bed. Resident 108 ' s room was observed with at least twenty small black flying insects. During a concurrent observation and interview on 6/25/2024 at 11:27 AM with Housekeeper (HK) 2 in Resident 108 ' s room. HK 2 stated, there are plenty of them (flies), everywhere, all the time. HK 2 stated, Resident 108 likes to bring food to his room, which attracts the small flying insects. HK 2 stated, he believed the small black flying insects were gnats. During an interview on 6/26/2024 at 2:55 PM with Certified Nurse Assistant (CNA) 8, CNA 8 stated, Resident 108 loved to bring fruits to his room all the times. CNA 8 stated, sometimes she sees apple, banana, orange peels on the floor. CNA 8 stated, she did not report the flies to the Charge Nurse. CNA 8 stated, she mentioned it to the Program Counselor (PC), who was assigned to Resident 108, when she saw the fruit on the floor last week because the resident was not allowed to bring food to his room. During an interview on 6/26/2024 at 3:18 PM with PC 2, PC 2 stated, he had been Resident 108 ' s assigned counselor for a few months. PC 2 stated fruits were given only during snack time, and he was not aware or received any report that Resident 108 had been taking fruits to his room. PC 2 stated, fruit could cause flies. During an interview on 6/26/2024 at 4:20 PM with the Director of Nurses (DON), the DON stated, there should not be flies in the resident ' s room. The DON stated, flies could increase risk for unsanitary living environment and increase risk for spreading infection. A review of the facility ' s policy and procedure (P&P) titled, Policies and Practices-Infection Control, revised October 2018, indicated the facility ' s responsibilities included to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general precautions.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to implement the facility ' s policy and procedure on smoking by ensuring five of five residents (Residents 104, 52, 69, 6, and 71) who were smokers (tobacco users) were provided a safe and hazard free environment when smoking. The facility failed to: 1. Ensure to have metal containers, with self-closing cover readily available in the smoking areas. 2. Ensure the residents were monitored and supervised to ensure the cigarette butts were disposed in the metal container and not on a plastic trash bin or on the ground in the smoking area. These failures had the potential to result in fire and accidental burn to the residents that could affect the health, safety and wellbeing of all 144 residents, facility staff and visitors. Findings: 1. A review of Resident 104 ' s Admission Record indicated Resident 104 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (mental illness that include hallucinations [false perceptions of reality such as hearing voices or seeing images that are not real] and/or delusions [fixed, false beliefs that conflict with reality]) and type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A review of Resident 104 ' s Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 4/3/2024, indicated Resident 104 was cognitively intact (able to think, remember, and reason), and needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) in eating, oral and personal hygiene, and showering and bathing. A review of Resident 104 ' s care plan initiated on 1/5/2023, indicated the resident was at risk for injury related to smoking. To reduce the risk for injuries from smoking, the facility will explain the protocol and educate the resident and his/her family about smoking and will provide supervision while resident was smoking. A review of Resident 104 ' s Smoking assessment dated [DATE], indicated Resident 104 was unable to safely light and extinguish own cigarette and required supervision. 2. A review of Resident 52 ' s Admission Record indicated Resident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizoaffective disorder, bipolar type (a combination of symptoms of schizophrenia [mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions]), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), right knee pain. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 52 ' s MDS dated [DATE], indicated moderate cognitive impairment and required supervision in eating, oral and personal hygiene, and showering/bathing. A review of Resident 52 ' s care plan indicated the resident was at risk for injury related to smoking. To reduce the risk for injuries from smoking, the facility will explain the protocol and educate the resident and his/her and family about smoking and will provide supervision while resident was smoking if resident is not able to smoke independently. A review of Resident 52 ' s Smoking assessment dated [DATE] indicated Resident 52 was alert and able to smoke independently with an oversite supervision. 3. A review of Resident 69 ' s Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type, anxiety disorder, and unspecified dementia, mild, with agitation (impaired ability to remember, think, or make decisions that interfere with daily life). A review of Resident 69 ' s MDS dated [DATE], indicated severe cognitive impairment and required supervision in eating, oral and personal hygiene, and showering/bathing. A review of Resident 69 ' s care plan, dated 2/2/2022, indicated the resident was at risk for injury related to smoking. To reduce the risk for injuries from smoking, the facility will explain the protocol and educate the resident and his/her and family about smoking and will provide supervision while resident was smoking. A review of Resident 69 ' s Smoking assessment dated [DATE], indicated Resident 69 was unable to safely light and extinguish own cigarette and required supervision. 4. A review of Resident 6 ' s Admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified schizoaffective disorder (a mix of schizophrenia symptoms such as hallucinations and delusions and mood disorder symptoms), anxiety disorder, major depressive disorder (mental health condition that causes persistently low or depressed mood and a loss of interest in activities that once bought joy), paranoid schizophrenia (symptoms of schizophrenia including hallucinations and delusions), and right eye blindness (inability to see or lack of vision in the right eye). A review of Resident 6 ' s MDS dated [DATE], indicated severely impaired cognitive skills for daily decision making and required supervision in eating, oral and personal hygiene, and showering/bathing. A review of Resident 6 ' s care plan dated 7/24/24, indicated the resident was at risk for injury related to smoking. To reduce the risk for injuries from smoking, the facility will explain the protocol and educate the resident and his/her and family about smoking and will provide supervision while resident was smoking if resident is not able to smoke independently. A review of Resident 6 ' s Smoking Assessment, dated 9/19/2019, indicated Resident 6 was unable to safely light and extinguish own cigarette and required supervision. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A review of Resident 71 ' s Admission Record indicated Resident 71 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type, and unspecified extrapyramidal and movement disorder (involuntary movements that you cannot control, common when taking medications for schizophrenia). A review of Resident 71 ' s MDS dated [DATE], indicated moderate cognitive impairment and required supervision in eating, oral and personal hygiene, and showering/bathing. A review of Resident 71 ' s care plan dated 4/27/24, indicated the resident was at risk for injury related to smoking. To reduce the risk for injuries from smoking, the facility will explain the protocol and educate the resident and his/her and family about smoking and will provide supervision while resident was smoking if resident is not able to smoke independently. A review of Resident 71 ' s Smoking assessment dated [DATE], indicated Resident 71 was unable to safely light and extinguish own cigarette and required supervision. During a concurrent observation and interview on 06/25/24 at 4:14 PM at the backyard smoking area with Certified Nursing Assistant (CNA) 4, only one metal smoking bin without self closing cover was observed, cigarette butts were observed scattered all over the grounds of the smoking area where there was dried grass, trees and where the laundry building was. Another CNA and four counselors were observed monitoring residents. CNA 4 stated, the metal bin was the one smoking bin where residents need to throw the cigarette butts and had no cover. Also stated cigarette butts should not be disposed on the floor, grass or regular trash as it could cause fire, that cigarette butts should be disposed in the metal bin provided. During an observation on 06/25/24 at 4:20 PM of the smoking area, smelled cigarette smoke and burning plastic material in the regular trash bin lined with plastic next to the door to go back into the facility. Three cigarette butts were observed inside the regular trash, six cigarette butts were scattered on the ramp leading to the facility door. During an interview on 06/25/24 at 4:22 PM of the smoking area with (CNA) 3, CNA 3 stated cigarette butts disposed in the regular trash is dangerous as it could cause fire. During an interview on 06/25/24 at 04:25 at the backyard smoking area with Mental Health Worker (MHW) 1 and Program Counselor (PC) 1, MHW 1 and PC 1 stated they were watching Residents 104, 52, 69, and 6. Residents 104, 52, and 69 were able to hold the cigarettes but had difficulty walking while Resident 6 and 71 were being monitored for wandering off and for proper disposal of cigarette butts. Resident 71 was being monitored for smoking safety and proper disposal of cigarette butt. Also stated, all residents were monitored to make sure they do not share their cigarettes with each other, pick up something from the backyard and bring back inside the facility or bring their cigarettes back into the facility. During a concurrent observation and interview on 06/25/24 at 4:28 PM with MHW 1, PC 1, and CNA 4 stated they counted 3 cigarette butts in the regular trash, counted more than 30 cigarette butts in the area close to the facility building on the dried grass, the regular trash by the door is new and recently emptied. MHW 1 and PC 1 stated the cigarette butts on the floor are from morning shift. (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	06/28/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent follow up observation of the smoking area, and interview on 06/26/24 at 1:11 PM, with CNA 5, stated there were no metal bins with self-closing covers in the smoking area yesterday, there was only one metal bin without a cover. CNA 5 stated the presence of surveyors in the facility was good because the administration provided the correct disposal metal bins for the cigarette butts. During an interview on 06/26/24 at 1:40 PM, PC 2 stated residents were instructed to throw the cigarette butts in the metal ash trays with cover to prevent fire. PC 2 stated there were two new metal bins with covers in the back part of the smoking area, and another new one in the front part of the smoking area. PC 2 confirmed there were more than thirty cigarette butts scattered around the grounds of the whole smoking area. During a follow up interview on 06/26/24 at 1:48 PM, PC 1 and MHW 1 stated the three metal bins are new and were not in the smoking area yesterday. During a concurrent interview and record review on 06/28/24 at 10:15 AM with the Director of Nursing (DON), the smoking policy was reviewed. DON stated smoking assessment were done on admission, there were three smoke breaks daily, two CNAs and four counselors were present to supervise residents on smoke breaks to make sure they were not sharing their cigarettes to other residents, residents were safe from cigarette burns, make sure cigarette butts were placed in the metal bin with cover after smoke break was over, and make sure they do not bring anything from the backyard back inside their rooms. DON stated she was not aware there were no metal bins with cover for safe disposal of cigarette butts in the backyard smoking area. A review of the facility ' s Policy titled Smoking Policy - Residents, revised July 2017, indicated metal containers, with self-closing cover devices, are available in smoking areas, the resident will be evaluated on admission to determine if he or she is a smoker or non-smoker; any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues; and any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. A review of the facility ' s policy titled Smoking Policy, revised on 10/27/2021, indicated residents will be required to place their cigarette butts in the metal canister provided as they exit the smoking area