

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024
NAME OF PROVIDER OR SUPPLIER Crescent City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1280 Marshall Street Crescent City, CA 95531	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41175</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services that meet the needs of the residents when two of four sampled residents (Residents 1 and 2) did not receive their medications in a timely manner. These failures were not in alignment with the facility policy and procedures and had the potential to not meet the residents' therapeutic needs which could lead to the worsening of their health conditions.</p> <p>Findings:</p> <p>1. During an interview on 12/26/24 at 3 p.m., Resident 1 stated her medication Carbidopa-Levodopa (used to treat the symptoms of Parkinson's disease [shaking palsy]) was scheduled three times a day but would often receive them late. Resident 1 stated even today's doses were more than an hour late. Resident 1 stated she would have preferred it if nurses would give her medications on time.</p> <p>During an interview on 12/26/24 at 3:15 p.m., Licensed Nurse A stated medications were supposed to be administered within an hour of its schedule.</p> <p>During a concurrent interview and record review on 12/26/24 at 5:40 p.m. with the Administrator, Resident 1's Levodopa-Carbidopa Administration History, dated 12/12/24-12/26/24, was reviewed. The Administration History indicated the medication was scheduled for 0700 (7 a.m.), 1200 (12 p.m.) and 1700 (5 p.m.). The Administration History indicated the medications were administered at 08:46 (8:46 a.m.) and 13:59 (1:59 p.m.) on 12/26/24. Further review of the Administration History indicated the medication was administered an hour past its schedule 22 other times during the period of 12/12/24 to 12/26/24. The Administrator stated the medications were given late.</p> <p>During an interview on 12/26/24 at 6:05 p.m., the Administrator stated medications were supposed to be given as scheduled, per the physician's orders. The Administrator stated delays in medication administration could worsen the residents' symptoms.</p> <p>2. During an interview on 12/24/24 at 1:50 p.m., Family Member (FM) stated it was upsetting when nurses were hours late in giving Resident 2 her scheduled 9 a.m. medications on 11/28/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 2's MEDICATION ADMINISTRATION RECORD , dated 11/1/24-11/30/24 , indicated Resident 2 had three medications scheduled to be administered at 9 a.m. on 11/28/24: Metoclopramide (used to treat or prevent nausea and vomiting), Vitamin D3 (used to treat and prevent bone disorders) and Metoprolol Tartrate (used to lower the blood pressure).</p> <p>During a concurrent interview and review on 12/30/24 at 2 p.m. with the Administrator, Resident 2's Vitamin D3 Administration History, Reglan Administration History, and Metoprolol Tartrate Administration History were reviewed. The Administration Histories indicated the medications were administered on 11/28/24 at 11:30 a.m., 11: 28 a.m., and 11:31 a.m., respectively. Further review of the Administration Histories indicated the medications were given an hour past their schedule multiple times: seven occurrences during the period of 11/25/24 to 12/9/24 for the Vitamin D, 12 other times during the period of 11/25/24 to 12/4/24 for the Reglan, and nine other times during the period of 11/25/24 to 12/9/24 for the Metoprolol Tartrate. The Administrator stated were late, as they were given an hour past their schedule.</p> <p>A review of the facility policy titled, Medication - Administration , dated January 01, 2023 , indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines . B. The Licensed Nurse will prepare medications within one hour of administration. i. Medications may be administered one hour before or after the scheduled medication administration time.</p>		