

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 03/13/2025
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 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>39792</p> <p>Based on interview and record review the facility failed to follow their smoking policy for one out of two sampled residents (Resident 3), when one unlicensed staff was vaping (the action of inhaling and exhaling vapor containing nicotine and flavoring produced by device designed for this purpose) in Resident 3 ' s room.</p> <p>This failure had the potential for Resident 3 to have vapor inhalation health consequences.</p> <p>Findings:</p> <p>During an interview on 3/12/25 at 11:11 a.m., Licensed Staff A stated the facility received a complaint that Unlicensed Staff B had been vaping in Resident 3 ' s room. Licensed Staff A stated she reported the complaint to the Administrator.</p> <p>During a concurrent interview and record review on 3/12/25 at 2 p.m., with the Administrator, Unlicensed Staff B ' s Investigation Attestations (document the includes a description of what happened in the employee ' s own words) was reviewed. The Administrator confirmed Unlicensed Staff B had admitted to vaping in Resident 3 ' s room as indicated on the investigation attestation and signed by Unlicensed Staff B. The Administrator added Unlicensed Staff B had been suspended and upon his return was provided training related to facility ' s smoking policy, specifically, no vaping allowed in the facility.</p> <p>During an interview on 3/12/25 at 5:41 p.m., with Director of Staff Development (DSD), the DSD stated Unlicensed Staff B admitted to her that he was vaping in Resident 3 ' s room. The DSD confirmed Unlicensed Staff B was provided training on facility's smoking policy.</p> <p>During a review of the facility ' s policy and procedure titled, NON-SMOKING POLICY dated 6/1/24, indicated, If smoking is allowed at this facility, if should only occur in designated areas on Company property. Employees should see their supervisor to determine if there is a designated smoking area at their facility.</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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