

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 05/01/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088</p> <p>Based on interview and record review, the facility failed to implement measures to prevent an elopement for one of three sampled residents (Resident 1), when he was observed in front of the facility without staff assistance.</p> <p>This failure had the potential for injury from falls and other negative impacts on Resident 1's safety and security.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated he was admitted [DATE] with Diagnoses that included Traumatic Brain Injury (Brain injury related to an accident), Muscle Weakness, Cognitive Communication Deficit (Difficulty in making needs known), Psychosis (A brain condition that results in difficulties determining what is real and what is not real), Anxiety, Insomnia (Inability to sleep or stay asleep), Bipolar (A mental disorder characterized of depression and elevated mood that may last days or weeks) and Schizophrenia (A mental disorder characterized by hallucinations, seeing things that are not there and disorganized thoughts).</p> <p>A review of Resident 1 ' s clinical record included documentation of elopement attempts since admission. Review included medical orders that indicated on [DATE], an individual alarm known as a Wander Guard, was placed on Resident 1, tracking his elopement attempts. Medical orders included staff to check placement of the Wander Guard every shift. An order for a sit-stand alarm was initiated [DATE].</p> <p>A review of Resident 1 ' s clinical record included the following documents:</p> <p>A Minimum Data Set (MDS - a federally-mandated resident assessment tool), dated [DATE], indicated Resident 1 had severe memory impairment, with a Brief Interview for Mental Status (BIMS) score of 5 (, d+[DATE] score indicated resident was severely cognitively impacted).</p> <p>During an interview on [DATE] at 12:20 p.m., the Receptionist stated Resident 1 had a consistent pattern of wanting to walk home. She stated he had a Wander Guard device, and a sit-stand alarm. She stated he was supposed to be escorted back to his room after every meal. She stated she was not working on the day of his elopement, [DATE]. She stated she monitored the doors when she was working but did not know how the front doors were monitored on the weekends.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 12:55 p.m., Unlicensed Staff C stated Resident 1 was a, Runner. He stated Resident 1 was supposed to be escorted to the dining room for meals and, immediately after he had completed his meals, he was supposed to be escorted back to his room. He stated Resident 1 had a long history of trying to elope, and everybody tried to keep him away from the front doors. Unlicensed Staff C stated he thought Resident 1 was able to elope through the front doors because he had remained in the dining room after dinner while staff were taking other residents back to their rooms, and they left Resident 1 alone in the dining room. He stated they were supposed to take Resident 1 first. Unlicensed Staff C stated Resident 1 ' s Wander Guard did not alert and the sit-stand alarm did not initiate either. He stated the sit-stand alarm was attached to his jacket and Resident 1 had taken it off before exiting through the front doors.</p> <p>During an interview on [DATE] at 1:15 p.m., the DON stated Resident 1 was at high risk for elopement. She stated he had a Wander Guard on his helmet that was never removed from his head, and a sit stand alarm on his jacket. She stated after Resident 1 had eloped and returned, they checked his Wander Guard, and the Wander Guard battery had expired and did not activate the alarm at the front door. She stated, if Resident 1 ' s battery had been tested daily the expired battery would have been discovered.</p> <p>During an interview on [DATE] at 2 p.m., with the Administrator, she stated Resident 1 had eloped on the weekend and she was notified by staff. She stated neighbors of the facility observed Resident 1 on the sidewalk and encouraged him to sit down on the curb since he appeared tired. She stated they walked into the facility and informed staff that a resident was alone in front of the facility. She stated Resident 1 had been assessed for any injuries and none were observed. She stated his Wander Guard device was tested , and it did not initiate the alarm at the front door. She stated Resident 1 had eloped through the front doors after dinner, and he was supposed to have been monitored by staff and taken back to his room. She stated he walked out of the facility because he was not monitored. She stated the facility was at fault for Resident 1 ' s elopement on [DATE].</p> <p>During a review of a facility policy and procedure titled, Elopement Risk Reduction Approaches, dated , d+[DATE], it indicated, Accompany wandering residents on their journeys when supervision is required to ensure safety or encourage a meaningful, alternate activity.</p>		