STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056296	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent City Care Center	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide privacy and confidentiality for one of four sampled residents (Resident 2), when the facility physician conducted Resident 2's medical examination in a group setting, in front of other residents.This practice resulted in Resident 2 feeling embarrassed and unsatisfied with physician services, constituted a breach of Resident 2's confidentiality and may have adversely affected the quality of the diagnostic process. A review of Resident 2's admission Record (a facility demographic), dated 2/25/26, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including morbid obesity (an abnormally high body mass), depression (persistent, overwhelming feelings of sadness) and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity).A review of Resident 2's Minimum Data Set (MDS, an assessment tool), dated 1/27/26, indicated Resident 2 had little to no cognitive impairment.A review of a facility document titled, Resident Council Minutes, dated 1/20/26, indicated all participating residents, want to know if they can see a new physician.During a record review of electronic correspondence received from [Resident Advocate] to the agency on 2/09/26, multiple complaints were made on behalf of anonymous facility residents. This included allegations that the facility physician had conducted group examinations in the dining area, where resident privacy and confidentiality was not honored.During a phone interview on 2/25/26 at 12:45 p.m. with the facility physician [PHY], he stated he had many residents to see in the facility, who were not always in their rooms and were in other areas. The PHY stated he was only able to come to facility once a month and had to, chase down the residents where they are. The PHY stated he did recall conducting a few medical examinations among a group of residents in the dining area in January of 2026.During an interview on 2/25/26 at 2:24 p.m., Resident 2 stated she was, bothered, when PHY examined her in the dining room, and it made her feel embarrassed. Resident 2 also stated PHY, barely spent any time, with facility residents.A review of the facility policy and procedure (P & P) titled, Physician Visits and Physician Delegation, dated 12/19/22, indicated, the physician should.review the resident's total program of care including medications and treatments at each visit.A review of facility P & P titled, Resident Rights, dated 2/19/22, indicated, the resident has a right to personal privacy and confidentiality.personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on interview and record review, the facility failed to develop a care plan focused on safety and monitoring for one of three sampled residents (Resident 1), who had reported experiencing suicidal thoughts (suicidal ideation).This finding may have resulted in failure to identify warming signs, insufficient risk reduction strategies, inadequate supervision and lack of essential safety measures, which could have contributed in Resident's suicide occurring just weeks after expressing suicidal ideation. A review of Resident 1's admission Record (facility demographic), dated 2/24/26, indicated he was admitted to the facility on [DATE], with diagnoses including malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it receives), difficulty walking, muscle weakness, and repeated falls. Resident 1 was [AGE] years of age.A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/09/26, indicated Resident 1 had little to no cognitive (mental process of acquiring knowledge and understanding through thought, experience, and the senses) impairment.A review of Resident 1's Social Service Progress Note, dated 2/12/26 at 3 p.m., indicated LATE ENTRY.mobile crisis team [mental health agency] came on 2/12/2026 approximately at 3 p.m. for an assessment on [Resident 1].A review of Resident 1's [County Mental Health] Progress Note, dated 2/12/26, indicated Resident 1 was evaluated by a mental health professional due to having depressive thoughts .made suicidal statements. Resident 1 explained he had issues with not liking facility food, felt weak, had problems hearing, and wanted to be placed in hospice (specialized care for people with terminal illnesses focusing on comfort, dignity, and quality of life rather than curing the illness) care. The progress note further indicated, [Resident 1] was able to work with [County Mental Health] and [facility] staff on meeting some of [Resident 1's] needs.A review of Resident 1's Progress Note dated 2/16/26 at 3:02 p.m., indicated Resident 1 was found on the floor next to his bed after a fall, and complained of left shoulder pain. The physician ordered Resident 1 sent to [General Acute Care Hospital-GACH].A review of Resident 1's GACH History and Physical Note, dated 2/16/26, indicated Resident 1 was passively suicidal.states he does not like living at [facility] and that if he goes back he will kill himself.A review of Resident 1's GACH Hospital Discharge summary, dated [DATE], indicated Resident 1 had, no suicidal ideation.in shared decision making.[GACH] felt it was appropriate for [Resident 1] to be discharged .A review of Resident 1's Progress Note, dated 2/18/26 at 4 p.m., indicated Resident 1 was assessed and readmitted to the facility.A review of Resident 1's Progress Note, dated 2/19/26 at 6:22 a.m., indicated Resident 1 was found unresponsive and without vital signs on the bathroom commode, with copious amounts of blood on and around him. According to this note, a toenail cutting tool was seen near Resident 1.A review of Resident 1's Progress Note, dated 2/19/26 at 7:20 a.m., indicated Resident 1's official time of death as 7:20 a.m. on 2/19/26.During an interview on 2/25/26 at 10:30 a.m., the Director of Nursing (DON) stated residents exhibiting suicidal ideation were typically transferred to the hospital for psychological screening and clearance, as acute care settings could expedite this process. The DON further stated that, should a resident with suicidal tendencies remain at the facility, staff would implement safety measures such as removing call light cords and sharp objects, and provide one-to-one supervision. The DON stated that she would have expected social services to initiate a care plan addressing suicidal ideation for Resident 1, incorporating these interventions, or coordinating with nursing to begin such a plan. The DON stated that a behavioral contract for safety (a written or verbal agreement outlining actions to ensure personal safety and the safety of others) was not offered to Resident 1.During an interview on 2/25/26 at 11 a.m., the Administrator (ADM), stated the Social Service Director should have (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started a suicidal ideation safety care plan when Resident 1 first complained of suicidal thoughts on 2/12/26.During an interview on 2/25/26 at 2 p.m., the Occupational Therapy Assistant (OTA), stated encountering Resident 1 in the facility administration hallway. According to OTA, Resident 1 stated, It's hospice or suicide, and appeared frustrated. The OTA stated she then informed both the Social Services Director and a nurse (whose name she could not recall) about the incident.During a concurrent phone interview and record review on 3/09/26 at 11:30 a.m. with the facility ADM and DON, a follow-up record review of Resident 1's care plans was conducted. The ADM and DON acknowledged no care plan for suicidal ideation or self-harm safety was initiated for Resident 1 after his reported statements on 2/12/26 or 2/25/26.A review of the facility policy and procedure (P & P) titled, Behavioral Health Services, dated 12/19/22, indicated, the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes.ongoing monitoring of mood and behavior, care plan development and implementation.if a behavioral contract is used, it will only be used with residents with the capacity to understand.facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident.may include, but are not limited to.offering verbal reassurance especially in terms of keeping resident safe.A review of facility P & P titled, Suicide Prevention, dated 12/19/22, indicated, it is the policy of this facility to act quickly and appropriately if a resident expresses thoughts of suicide.all staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker.the resident will not be left alone.objectively document appropriately the resident's mood and behaviors, as well as all actions taken, in the medical record.