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	04/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the California Department of Public Health (the Department) within the required timeframe for one of two residents (Resident 1) when the facility did not report an allegation of abuse involving Resident 1 within two hours after the allegation was made.This failure had the potential to result in the allegation not getting investigated timely, and can result in physical, mental, or psychosocial harm to the residents. Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), and corticobasal degeneration (a rare, progressive brain disease that causes nerve cells to shrink and die, affecting movement, speech, and memory, often leading to immobility).A review of Resident 1's Nursing Progress Notes, dated 4/7/26, indicated during Resident 1's telepsychiatry visit (telepsych - mental health care-such as psychiatric evaluations, therapy, and medication management-from a doctor or therapist remotely via secure video calls or phone, rather than in a physical office), Resident 1 reported that some people in the facility tried to hurt him. A review of SOC 341 (a state form used by mandated reporters to report suspected abuse, neglect, or exploitation of elders or dependent adults), dated 4/7/26, indicated Resident 1 made the report the people that work here try to hurt me during the telepsych appointment on 4/7/26 at 11:30 a.m.During a concurrent interview and record review on 4/22/26 at 5:12 p.m., with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), the SOC 341, dated 4/7/26, was reviewed. The ADON stated she was with Resident 1 during the telepsych visit and heard Resident 2's report that some people in the facility tried to hurt him. The ADON stated she then informed the Administrator and had prepared the SOC 341 that the Administrator sent to the Department. The DON confirmed the SOC 341 indicated the allegation occurred on 4/7/26 at 11:30 a.m. The DON stated the SOC 341 was sent out to the Department by the Administrator electronically.During a follow-up interview with the DON on 4/22/26 at 6:01 p.m., the DON confirmed the date and time the SOC 341 was electronically sent by the Administrator to the Department was on 4/7/26 at 3:17 p.m. The DON did not respond when she was asked to confirm they reported the incident more than 3 hours after it was first reported. A review of the facility policy titled Abuse, Neglect and Exploitation dated 12/19/22, indicated, it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .all alleged violations are to be reported to the Administrator, state agency, adult protective services and to all other required agencies.immediately, but not later than 2 hours after the allegation is made.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) received treatment and care in accordance with the resident's goals of care and professional standards when Resident 2's skin treatment ordered by the physician was not provided for 11 days of the month. This failure had the potential to result in worsening of the skin condition and leaving the skin unprotected and broken rendering it susceptible to secondary infection. Findings:A review of Resident 2's admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including bleeding between the brain and its surrounding membrane, heart and lung failures, and other infectious diseases (illnesses caused by tiny organisms-such as bacteria, viruses, fungi, or parasites).A review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/3/26, indicated Resident 2 was admitted with one unstageable pressure sore (UTD - a deep, serious skin wound covered by dead tissue {slough or eschar} that prevents doctors from seeing how deep it actually goes), two deep tissue injuries (DTIs - a localized area of maroon or purple discolored intact skin, or a blood-filled blister, resulting from intense pressure or shear) and moisture associated skin damage (MASD) caused from prolonged exposure to moisture.A review of Resident 2's care plan (written roadmap or personalized action plan that outlines a resident's medical, personal, and emotional needs) for the DTI on the coccyx (a small, triangular area located at the very bottom of the spine often called a tailbone) and UTD on the right sacrum (a triangular-shaped area located toward the base of the spine, between lower back and the tailbone), dated 3/31/26, indicated interventions included administering medications/treatment as ordered and follow facility policies/protocols for the prevention/treatment of skin breakdown.A review of Resident 2's care plan for the potential for impaired skin integrity, dated 3/31/26, indicated interventions including, provide skin care per facility guidelines and as needed. A review of Resident 2's Treatment Administration Record (TAR) for 4/26, indicated a treatment order for bilateral buttocks with zinc and 3x3 foam dressing that was not provided by the afternoon shift for 11 days of the month on 4/1/26, 4/5/26, 4/6/26, 4/12/26, 4/14/26, 4/15/26, 4/17/26, 4/18/26, 4/19/26, 4/20/26, and 4/21/26. During an interview on 4/23/26 at 3:55 p.m., with the DON, the DON confirmed 11 of Resident 2's zinc treatments had not been completed as ordered in April 2026. The DON stated not giving the treatment as ordered poses the danger of infection and delay of healing.During a concurrent interview and record review on 4/23/26 at 5:25 p.m., with the DON, the facility policy titled, Medication Administration, dated 12/19/22, was reviewed. The DON pointed to item #14 of the policy which indicated, Medication are administered by licensed nurses., as ordered by the physician and in accordance with professional standards or practice. and stated that is what the facility failed to do.