

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 07/01/2026
NAME OF PROVIDER OR SUPPLIER Crescent City Care Center		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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to ensure dignity was maintained for one of three sampled residents (Resident 1) when a certified nurse assistant (CNA 1) disregarded the resident's right to refuse care and showered her despite her clear refusal. This failure resulted in a diminished sense of dignity and autonomy for Resident 1, causing anger, frustration, and anxiety, undermining her trust in caregivers, and creating the potential for psychological trauma and future reluctance to accept necessary care. A record review of Resident 1's admission Record (facility demographic), indicated her admission to the facility on 1/24/23 from an acute care hospital with diagnoses including but not limited to the following: muscle weakness, unsteadiness on feet, difficulty in walking, anxiety disorder (a mental health condition characterized by persistent and irrational worry, fear, or dread), post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a terrifying or life-threatening event), and claustrophobia (an intense irrational fear of confined or enclosed spaces). During an interview on 7/01/26 at 10:10 a.m., Resident 1 reported that on 5/27/26 she was forced to shower by facility staff despite clearly refusing and repeatedly telling them to stop. Resident 1 stated she yelled multiple times, but staff did not honor her refusal, leaving her feeling angry, fearful, and distrustful of caregivers. Resident 1 explained that she had previously developed trust with a specific certified nurse assistant (CNA 4) and had informed nursing staff that she preferred only CNA 4 to shower her. Resident 1 further reported having chronic shoulder pain and a history of childhood trauma related to bathing, which contributed to the emotional impact of the incident. A review of the 5th Day Investigation Report, submitted to the Department on 6/02/26 indicated that on 5/27/26 the facility initiated an investigation after Resident 1 reported being showered against her wishes by CNA 1. According to this report, the Director of Nursing (DON 1) and Administrator interviewed Resident 1 and notified the Department and local law enforcement. The report indicated Resident 1 stated she had refused the shower, and certified nurse assistant (CNA 2), confirmed Resident 1 was heard shouting during the incident. This report also indicated multiple witnesses, including CNA 1, substantiated that Resident 1 was showered despite her refusal. The facility completed safety checks, suspended CNA 1, and monitored Resident 1 following the report. After the investigation, CNA 1 was terminated. CNA 2 and a third certified nurse assistant (CNA 3), who witnessed portions of the incident, were counseled on their responsibilities in advocating for residents. During an interview on 7/01/26 at 3:11 p.m., the facility's new Director of Nursing (DON 2), reported her expectations for nursing staff following a resident's refusal of showering or bathing were to immediately stop, honor the resident's right to refuse care, report the refusal to the charge nurse, and for the staff involved to document the incident in the resident's medical record for follow up. DON 2 confirmed the risk in not honoring a resident's right to refuse shower care could result in a loss of dignity and diminished trust in care providers, and could have the potential to result in psychosocial harm. During an interview on 7/01/26 at 3:27 p.m., with the Social Services Director (SSD), the SSD stated every person should have the right to autonomy concerning their body, to direct the care of their body, and to refuse care. The SSD said prior to the showering incident that it was well known that Resident 1 generally only preferred one staff member, CNA 4, to shower her which was still (continued on next page)		

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's preference, even after the incident. The SSD confirmed Resident 1's care plan was updated after the showering incident to include an intervention specifically instructing staff to honor Resident 1's right to refuse shower care and to offer alternative hygiene methods as appropriate. Additionally, a psychiatry consult was performed for Resident 1 on 6/02/26. When queried, the SSD acknowledged Resident 1's rights, consent, and psychological protections were not recognized, assessed, and acted upon appropriately during the showering incident. A review of a psychiatry progress note dated 6/02/26 indicated Resident 1's clinical assessment by nurse practitioner (NP 1): CHIEF COMPLAINT. Follow-up after 05/27/2026 shower-care complaint. Today she reports anxiety/frustration around persistent left shoulder pain, painful handling during care. Anxiety/depressive burden appears amplified by pain, care-related distress. During an interview on 7/01/26 at 4:26 p.m., certified nurse assistant 5 (CNA 5) stated she had been trained by the facility during her orientation when a resident at any time refused care, to honor the resident's choice and stop immediately, report the refusal of care to the charge nurse and document the incident accordingly. A review of the Certified Nursing Assistant job description dated 2023, indicated, Major duties and responsibilities. Keeps nurse and supervisor informed of factors that interfere with being able to perform the work as assigned (i.e. resident refusal, .) . Additional Assigned Tasks. Treats all residents with dignity and respect. Promotes and protects all residents' rights. A review of the facility policy titled, Provision of Quality Care revised 12/19/22, indicated, Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. A review of the facility policy titled, Residents' Rights Regarding Treatment and Advance Directives revised 12/19/22, indicated, The facility will provide the resident. about the right to refuse. treatment. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart: a. What the resident refused. b. The reason for the refusal. c. The advice given to the resident about the consequences of refusing. d. The offering of alternative treatments. e. The continuation of providing all other services. 12. Any services that would be otherwise required, but are refused, will be documented in the resident's comprehensive care plan.		