

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  06/21/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39621</p> <p>Based on observation, interview and record review, the facility failed to ensure 15 out of 81 residents (Resident 25, Resident 68, Resident 6, Resident 12, Resident 55, Resident 29, Resident 40, Resident 35, Resident 3, Resident 65, Resident 21, Resident 46, Resident 50, Resident 2, &amp; Resident 58) were treated with dignity and respect when:</p> <ol style="list-style-type: none"> <li>1. The facility did not ensure Resident 25's sweater was changed after becoming soiled with food particles.</li> <li>2. The facility did not ensure Resident 68 was given a timely notice, and agreed to a room change, prior to transferring him to a new room.</li> <li>3. Resident 6's toenails were not trimmed for months, which caused her discomfort while wearing shoes.</li> <li>4. Resident 12's soiled clothing and disposable brief were not changed for several hours.</li> <li>5. Resident 55 had to wait 22 minutes sitting right next to another resident being fed, in order to be assisted with dining. By the time the other resident was finished, Resident 55's meal was cold, and had to be heated in the microwave.</li> <li>6. Resident 29, whose vision was severely impaired, and did not speak English, received no assistance with dining to guide her on the location of the different meal entrees.</li> <li>7. Resident 40 stated being treated with lack of dignity and respect by level-of-care staff, and explained how other residents were not provided with the care and services they needed.</li> <li>8. Resident 35, Resident 3, Resident 65, Resident 21, Resident 46, Resident 50, Resident 2, Resident 58 and Resident 25 expressed, during multiple interviews, that they were not being treated with dignity and respect by staff.</li> </ol> <p>These findings had the potential to result in feelings of shame, frustration, discomfort, sadness, and loss of control for the residents involved.</p> <p>Findings:</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Resident 25</p> <p>Record review indicated Resident 25 was admitted to the facility on [DATE] with medical diagnoses including Fracture of Left Femur (Thigh bone) and Need for Assistance with Personal Care (Dependent on staff for personal care such as showering, toileting, etc.), according to the facility Face Sheet (Facility demographic).</p> <p>During an observation on 6/10/24 at 10:09 a.m., Resident 25 was observed in bed, wearing a green sweater that had become extremely soiled with food particles. Resident 25 stated the food particles were from her breakfast meal. Resident 25 stated no staff had changed her sweater after breakfast that morning. Photographic evidence was taken with Resident 25's permission, of the sweater only [no faces or identifiable objects photographed]).</p> <p>During an interview with the Director of Nursing (DON) on 6/21/24 at 10:17 a.m., the DON stated breakfast was usually from 7:30 a.m. to 8:30 a.m. The DON was presented with the photograph of Resident 25's sweater the morning of 6/10/24 at 10:09 a.m. (above) and was asked about staff expectations after a resident had gotten soiled during meals. The DON stated Resident 25 should have been changed right away after getting soiled. In addition, the DON stated staff could have used a clothing protector to avoid getting food particles on Resident 25's clothing.</p> <p>2. Resident 68</p> <p>Record review indicated Resident 68 was admitted to the facility on [DATE] with medical diagnoses including Malignant Neoplasm of Floor of Mouth (Mouth Cancer), according to the facility Face Sheet.</p> <p>During a medication administration observation on 6/19/24 at 5:00 p.m., Resident 68 was telling the Licensed Nurse administering his medications how uncomfortable he felt in his new room, to which he had been recently moved, and asked if she knew when he would be moved to a room that had a window right next to his bed.</p> <p>During an interview with Resident 68 on 6/19/24 at 5:05 a.m., he stated he had been moved to his current room the morning of 6/19/24, and felt uncomfortable in this new room. Resident 68 stated that in his previous room, his bed was right next to the window, which he liked, and in addition, he got along with his roommate very well. Resident 68 stated he was not in agreement with this room change, but he had not been given any options. Resident 68 stated he had been notified about the room change 30 minutes to an hour before the room change. Resident 68 stated the Social Services Director had made this notification to him.</p> <p>During an interview with the Social Services Director on 6/20/24 at 6:26 p.m., she stated she got a request from the business office to move Resident 68 to another room the morning of 6/19/24 because they were admitting a resident that was imprisoned, and he needed to be placed in Resident 68's hallway, and since there were no beds available, they needed Resident 68's space. According to the Social Services Director, Resident 68 was asked for his permission, and he stated it was ok to move him. The Social Services Director stated both Resident 68 and his wife agreed to the room change, and she documented their approval on a paper form, to enter into the computer documentation system later in the day. When asked about the timing of the room change notification, the Social Services Director stated Resident 68 was notified right before the room change, the morning of 6/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Family Member AA on 6/20/24 at 1:10 p.m., she stated she did get notified by the Social Services Director about Resident 68's room change on 6/19/24, but she could not recall the Social Services Director asking for their permission or agreement with the room change. Family Member AA stated she definitely voiced to the Social Services Director that Resident 68 was not pleased with this room change, but it occurred regardless.</p> <p>During an interview with the DON on 6/21/24 at 10:17 a.m., she stated that if a resident was not in agreement with a room change, he should not be moved.</p> <p>Record review of the facility policy titled, Room or Roommate Change, last revised on January 24, 2018, indicated, The Facility reserves the right to make resident room changes or roommate assignments when the Facility deems it necessary or when the resident requests the change .Prior to changing a room or roommate assignment, the resident, the resident's representative (if available), the resident's new roommate, and the resident's current roommate will be given timely advanced notice of such change.</p> <p>35842</p> <p>3. Resident 6</p> <p>During a concurrent observation and interview on 6/10/24 at 10:34 a.m., Resident 6 stated she needed her toenails cut as they were really long. Resident 6 stated she has not had her toenails cut for months.</p> <p>During an observation and interview on 6/11/24 at 9:37 a.m., Resident 6 stated her toenails were so long her shoes were hurting her. When Resident 6 took off her clogs, Resident 6 had no socks on and her feet looked dry/unkept. Resident 6 allowed pictures of her feet to be taken. The pictures indicated Resident 6's feet/toenails were unkept, big toenails were approximately one-half inch long, and all other toenails were long, and needed to be trimmed. Resident 6's feet looked cracked and dry, and needed to be moisturized. Resident 6's feet/toenails had been neglected.</p> <p>During an interview on 6/12/24 at 12:10 p.m., Licensed Staff A was shown pictures of Resident 6's feet/toenails. Licensed Staff A stated it must be very uncomfortable for Resident 6 to wear socks and/or shoes because her toenails were so long. Licensed Staff A stated Resident 6's CNA (Certified Nursing Assistant) should have noticed Resident 6's feet during her shower or bed bath and told Resident 6's nurse, who should have assessed Resident 6's feet. Licensed Staff A stated an appointment should have been made for Resident 6 with the podiatrist. Licensed Staff A stated she would feel uncomfortable cutting Resident 6's toenails because they were so thick. Licensed Staff A stated it would be best for a podiatrist to cut Resident 6's toenails. Licensed Staff A stated she would have notified the social worker through Dashboard, the electronic medical record system.</p> <p>4. Resident 12</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 12's Admission Record indicated Resident 12 was admitted on [DATE], with a diagnosis that included paranoid schizophrenia (feeds into delusions (believes something that isn't true no matter how much evidence you give to the contrary), and hallucinations (involve the senses: seeing, feeling, or hearing something that isn't there), it's common for them to feel afraid and unable to trust others), chronic pain, borderline personality disorder (a mental illness that severely impacts a person's ability to manage their emotions), altered mental status (acute confusion state), amongst others.</p> <p>A review of Resident 12's Annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 5/15/24, indicated Resident 12 was severely cognitively impaired (causes serious issues with memory and our ability to reason, make decisions or even care for ourselves).</p> <p>During an observation on 6/10/24 at 5:09 p.m., Resident 12 was positioned on his back in bed with his head elevated, which was the same position Resident 12 was in at lunchtime. During lunch, four hours earlier, Resident 12 had spilled food all over the front of his shirt. Resident 12 was still wearing the same soiled shirt. He had not been assisted in putting on a clean shirt since lunchtime.</p> <p>During an observation on 6/12/24 at 6:05 p.m. Resident 12 was sitting up in bed getting ready for dinner wearing a soiled shirt. During an observation at lunchtime Resident 12 had soiled his shirt while eating his lunch in bed. This was the same soiled shirt Resident 12 had soiled at lunchtime. During two lunch observations staff never offered Resident 12 anything such as a cloth napkin, especially since he tended to spill on himself while feeding himself.</p> <p>During a concurrent observation and interview on 6/12/24 at 11:23 a.m., Resident 12 was dressed and sitting up in his wheelchair next to his bed. Resident 12 stated he had been up and dressed since breakfast. Resident 12 stated he had gone to the Main Dining Room for breakfast, which he stated he liked. Resident 12 stated he thought it was around 8 a.m. when he had his breakfast in the Main Dining Room. Resident 12 stated he had been waiting an hour for assistance back to bed. Resident 12 stated he had not been changed since he got up, which he thought was around 8 a.m. (3 1/2 hours ago). Resident 12 had a Hoyer lift (a device designed to assist caregivers in safely transferring patients) pad under him, which looked uncomfortable.</p> <p>During an interview on 6/12/24 at 1:05 p.m., Unlicensed Staff M stated Resident 12 had been up since 6:30 a.m. Unlicensed Staff M stated Resident 12 had been assisted up early so he could go down to the Main Dining Room for a special Country breakfast. Resident 12 had been up for five hours and his brief had not been changed for at least five hours. Unlicensed Staff M stated she did ask Resident 12 if he wanted to go back to bed after breakfast but he had not wanted to go back to bed yet. Note: Resident 12's breakfast time was 7 a.m. because he went down to the Main Dining Room for breakfast.</p> <p>5. Resident 55</p> <p>The facility document titled, Meal Service Time indicated residents who went to the Main Dining Room were the first to be served their meal tray, which was 7:00 a.m. for breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/10/24 12:18 p.m. in the Assisted Dining Room, eight residents were either being totally assisted or set-up and assisted as needed. Unlicensed Staff C was feeding Resident 52, who was a total assist. Resident 55 was sitting at the table next to Resident 52 waiting to be fed while the seven other residents were either being fed or had been set-up and were feeding themselves.</p> <p>During an observation 6/10/24 at 12:40 p.m., Unlicensed Staff C was done feeding Resident 52 and was just starting to feed Resident 55, 22 minutes later. Unlicensed Staff C had to heat up Resident 55's food in the microwave because Resident 55's hot food had gotten cold while waiting 22 minutes to be fed.</p> <p>6. Resident 29</p> <p>A review of Resident 29's Administration Record, indicated Resident 29 was admitted [DATE], with a diagnosis of sequelae of cerebral infarction (stroke caused by disruption of blood flow to the brain), convulsions (involuntary contracture of the muscles), feeding difficulties, muscle weakness, blindness right and left eye, dementia (more confused and forgetful), psychotic disturbances (confused thinking, delusions - false beliefs that are not shared by others, hallucinations - hearing, seeing, smelling or tasting something that isn't there, changed behaviors and feelings), anxiety, major depression, and hemiplegia (paralysis of one side of the body), amongst others and Resident 29's Primary language was Spanish.</p> <p>A review of Resident 29's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/12/24, indicated Resident 29 could not complete a BIM (Brief Interview of Mental Status), had a memory problem and cognitive skills for daily decision making was severely impaired, one upper extremity and both lower extremities had functional limitation of range of motion, and Resident 29 needed supervision or touching assistance with eating (The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or once the meal is placed before the resident).</p> <p>During an observation on 6/12/24 at 12:40 p.m., there was two staff members (Unlicensed Staff C and a nurse) for nine residents in the Assisted Dining Room. Resident 29 was trying to communicate in Spanish but was being ignored. The staff in the Assisted Dining Room did not speak Spanish, so staff could not understand Resident 29 in order to meet her dining needs. Unlicensed Staff C nor the nurse got someone to communicate with Resident 29 in Spanish. Resident 29 was legally blind and no staff member was sitting next to Resident 29 to guide her on where her food was on her plate. Unlicensed Staff C and the nurse were both sitting at the other end of the table feeding a resident. Unlicensed Staff C did place a plate guard (helps prevent food from accidentally being pushed off the plate while eating, minimizing spills at mealtime) on Resident 29's plate and handed her a fork. Resident 29 started eating her pasta with her fingers and still no one came over to sit next to Resident 29 to guide her with using her fork and with the placement of food items on her plate. Resident 29 was not offered a washcloth after she ate her pasta with her fingers.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/24 at 12:33 p.m., the DON (Director of Nursing) stated there were a few staff, such as the lead housekeeper and an Activities Assistant who spoke Spanish but they were gone for a few months and a few CNAs who could interpret for Resident 29. The DON stated, Yes, it was a dignity issue if a resident had to use their fingers to feed themselves like Resident 29, who was legally blind and cognitively impaired because a nurse or CNA was not available to assist the resident with their meal or snack. It was a dignity issue if Resident 29, whose primary language was Spanish, did not have a staff member to communicating with Resident 29 in Spanish in order to guide Resident 29 on where her food was placed on her plate/meal tray.</p> <p>During an interview on 6/13/24 at 2:30 p.m., Unlicensed Staff C stated it was a dignity issue when residents had to wait to be fed. Unlicensed Staff C stated a resident who was incontinent should be changed every two hours. Unlicensed Staff C stated a resident should not wait no more than three to five minutes for a staff member to answer their call light.</p> <p>7. Resident 40</p> <p>During an interview on 6/20/24 at 6:02 p.m., Resident 40 stated he did need assistance transferring from his wheelchair to the toilet. Resident 40 stated how staff treated him depended on their mood and how their day was going. Resident 40 felt the CNAs were too young and had not lived yet. Resident 40 stated he wanted the staffs' attitude to stop at his room door. Resident 40 stated when a resident vomited on herself by the Nurses Station, staff did not take her back to her room to clean her up. The staff left the resident out by the Nurses Station with vomit all over her. Resident 40 stated when the nurses or CNAs came into his room, he wanted the bullshit to stop. Resident 40 stated the residents were here for a reason and needed to be treated with dignity and respect. Resident 40 stated a CNA would come into his room, turn off his call light, and then he would wait ten minutes to one hour. Resident 40 stated he would use the call light because he needed to be transferred to use the bathroom either to urinate or have a bowel movement. Resident 40 stated her wore a brief too. Resident 40 stated the staff should be at the facility to take care of us, the residents, but many he feels were just working for a paycheck. Resident 40 repeated, Really feels like staff were just here for the paycheck.</p> <p>27532</p> <p>8. Resident 35, Resident 3, Resident 65, Resident 21, Resident 46, Resident 50, Resident 2, Resident 58 &amp; Resident 25</p> <p>During an interview on 6/10/24, at 10:57 AM, Resident 35 stated he had to wait two hours for assistance because staff had called off. Resident 35 stated four of seven days a week he had to wait to be cleaned.</p> <p>A review of Resident 35's annual MDS, dated [DATE] indicated he was cognitively intact with a BIMS score of 15, had not rejected assistance with activities of daily living, was dependent for maintaining perineal hygiene, required maximal assistance to roll from lying on back to left and right side, occasionally unable to control urination and frequently had no control with bowel movement.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/24, at 11:58 AM, Resident 3 stated it takes as long as four to six hours for staff to respond to calls for assistance. Resident 3 stated she had experienced lying in her urine and feces while waiting. When asked how she felt, Resident 3 stated it burned her skin and bothered her when she was made to lie in her urine and feces and wait for assistance.</p> <p>A review of Resident 3's quarterly MDS dated [DATE] indicated she has memory problems but able to recall her room location.</p> <p>During an interview on 6/10/24, at 12:11 PM, Resident 65 confirmed Resident 3's statement regarding the long wait time for CNAs. Resident 65 stated she and Resident 3 had to help each other to call for assistance. Resident 65 further reported: Unlicensed Staff D would come in the room at night and growl and call loudly to wake Resident 3, and in the process wake Resident 65 and give her a headache. When Resident 65 told him to lower his voice, Unlicensed Staff D just looked at her and loudly spoke to Resident 3 in Spanish. When she told him, she will report him if he persists, he came back at 1 AM, and greeted her in a very loud voice. Resident 65 felt Unlicensed Staff D wanted to aggravate her by speaking in a loud voice. Once he came in and forcefully whipped a plastic bag near her head exacerbating her migraine. Resident 65 felt very disrespected. At another time when she asked Unlicensed Staff D if he was the one to push her back to her room, he looked at her and responded: I will think about it. and not do it. Unlicensed Staff D would respond to questions with: If I have time and leave the room. Resident 65 felt Unlicensed Staff D was working under the influence of something. He was inconsiderate, and she felt he was harassing her. At another time, Resident 65 was in the wash room when Unlicensed Staff D just came in to wet the washcloth to wash Resident 3 with.</p> <p>During the Resident Council meeting on 6/11/24 at 1:33 PM, the seven residents present (Resident 21, Resident 6, Resident 46, Resident 50, Resident 2, Resident 58, and Resident 25) were asked how staff treat them with respect and dignity so that they do not feel afraid, humiliated or degraded. Resident 21 stated Certified Nursing Attendants (CNAs) do not treat them with respect. Resident 21 stated Unlicensed Staff F was rude and refused when requested to supervise a resident who needed supervision while smoking. Resident 21 also stated, on another occasion Unlicensed Staff D turned and walked away when spoken to by the resident. This annoyed Resident 21 and made her very angry.</p> <p>A review of Resident 21's admission Minimum Data Set (MDS - federally mandated clinical assessment of all residents' functional capabilities in Medicare and Medicaid certified nursing homes helping nursing home staff identify health problems) dated 4/5/24, indicated she was cognitively intact with a Basic Interview for Mental Status (BIMS - tool used to screen and identify the cognitive condition of residents) score of 15.</p> <p>During the same meeting on 6/11/24 at 1:33 PM, Resident 50 stated Unlicensed Staff G refused to get her dessert as Resident 50 requested. This made Resident 50 angry and made her curse.</p> <p>A review of Resident 50's 5-day scheduled assessment MDS dated [DATE] indicated she was cognitively intact with a BIMS score of 15.</p> <p>During an interview on 6/11/24, at 2:24 PM, Resident 25 stated she had a hard time getting someone to help her. She could not say when, but she had waited two to three hours, three to four times a week sitting in her urine or feces. Resident 25 stated she felt so bad and awful.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>27532</p> <p>Based on interview and records review, the facility failed to provide seven of seven residents (Resident 21, Resident 6, Resident 46, Resident 50, Resident 2, Resident 58, and Resident 25) the contact information of the California Department of Public Health where they can file complaints regarding possible abuse, neglect, exploitation, amongst other possible violation of state or federal regulations. This failure left the residents not knowing and deprived them their right to be able to formally file a complaint to the State about the care they were receiving at the facility.</p> <p>Findings:</p> <p>During an interview at the Resident Council meeting on 06/11/24, at 2:40 PM, when asked if they knew how to contact the Department to file a complaint, none of the seven residents present knew how and where to contact the State.</p> <p>A review of the regulatory Health and Safety Code S483.10(g)(4)(i)(C)(D)(ii)(vi) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and language he or she understands, including: Required notices as specified . The facility must furnish to each resident a written description of legal rights which includes - A list of names, addresses (mailing and email), the telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency .A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, .information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, .information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations but not limited to resident abuse, neglect, exploitation .</p> <p>A review of the facility's policy on resident rights dated 10/16/21 did not indicate the residents' right to information to contact the Department to formally file complaints on possible violations to federal or state regulations.</p>		

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NAME OF PROVIDER OR SUPPLIER  Crescent City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1280 Marshall Street Crescent City, CA 95531	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27532</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure the environment was kept free of offensive odors throughout the building. At all times of the day, an unpleasant smell which consisted of feces, urine and strong body odors permeated the air inside the facility. This finding had the potential to result in discomfort, headache, nausea, eye and nose irritations, among many other symptoms, to the residents of the facility.</p> <p>Findings:</p> <p>During an observation, while entering the building for the first time during the recertification survey, on 6/10/24 at 8:45 a.m., the smell in the hallways of the facility was almost unbearable. The odor smelled like a combination of human feces and urine, strong body odors, dirt, and grime. The hallway was covered by a dark carpet that had visible stains in several areas.</p> <p>During initial tour of the facility on 06/10/24, at 8:45 AM, a foul odor was noted in the North Hall.</p> <p>During a concurrent observation and interview on 6/10/24 at 10:16 a.m., Resident 27's room smelled so bad, the odor was unbearable. Neither Resident 27, nor his roommate where inside the room at the time. Unlicensed Staff C came into the room and confirmed the offensive odor. Unlicensed Staff C proceeded to remove Resident 27's top bedsheet from his bed, and noticed the sheets underneath were soaked with urine and feces.</p> <p>During an observation on 6/11/24, at 8:25 AM walking through the North Hall from the lobby passing through rooms 125 down to 133 noted the foul odor of something like a combination of sweat, urine, and body odor.</p> <p>During continued observation on 6/12/24, at 8:39 AM, the same strong foul odor in the North Hall was noted.</p> <p>During an interview on 6/12/24, at 5:32 PM, when asked if she noted the foul odor in the hallway especially the North Hall, the IP stated she had not noticed the foul smell in the hallway especially North Hall. The IP stated nobody reported the foul odor to her, otherwise she could have addressed it.</p> <p>During continued observation on 6/13/24, at 8:26 AM, the foul odor was again noted while walking down the North Hall. The foul odor was again noted in the North Hall on 6/13/24 3:15 PM.</p> <p>During an interview on 6/14/24, at 11:06 AM, Unlicensed Staff K when asked what the reason is why the North Hall smell so bad, stated the musty smell in the North Hall could be because there were more residents in the hall who eliminate urine or feces in bed. Unlicensed Staff K stated, the Janitor shampooed the carpet every week.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/14/24, at 11:18 AM, when asked what she can smell in the North Hallway, the ADON stated she can smell deodorant spray. When asked why the North Hall especially from across room [ROOM NUMBER] down the hallway smell bad, the ADON stated she thinks the smell on North Hallway especially by room [ROOM NUMBER] was because both residents could have their linens/bedding wet with urine especially in the morning and will smell if not changed soon.</p> <p>During an interview with Resident 14 on 6/14/24 at 11:30 a.m., she confirmed the odor in the facility was very offensive but stated she had gotten used to it by now, so she could barely smell it anymore.</p> <p>During an interview with Resident 40 on 6/14/24 at 3:15 p.m., he confirmed the facility smelled, awful, and stated his family, who visited him often, had complained about the odor. Resident 40 stated that he had gotten used to it, but when he was first admitted to the facility, the odor really bothered him. Resident 40 stated he felt the odor was partially caused by the lack of sufficient staff, who did not change the briefs and soiled clothing of the residents often enough. Resident 40 stated he had observed residents who had vomited, sitting in front of the nursing station with their clothing full of vomit, and no one would change them.</p> <p>During an interview with the Director of Nursing (DON) on 6/21/24 at 10:17 a.m., she stated being aware of the offensive smell in the environment. The DON stated that when she was first hired, approximately a year ago, she bought several air fresheners for her office, because the smell was bothersome, but now, she had gotten used to it.</p> <p>Record review of the facility policy titled, Resident Rooms and Environment, last revised on 1/01/21, indicated, The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order. D. Pleasant, neutral scents. E. Comfortable levels of ventilation.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35842</p> <p>Based on interview and record review the facility failed to ensure one of 23 sampled residents (Resident 51) clinical record included a physician discharge order, a completed signed Discharge Assessment and a physician Discharge Summary of Care. The lack of completed discharge documentation had the potential to result in the lack of communication between the facility, the physician, and Resident 51 and/or Resident 51's responsible party, and a potential to affect continuity of care, such as Resident 1's overall readiness for discharge, medication, activities, diet, and/or follow-up visits, which could have impacted Resident 51's continuity of care leading to an unsafe discharge to home. In addition, Resident 51's physician not completing Resident 51's Summary of Care had the potential for the next care provider to receive insufficient information to properly care for the resident, which could impact the resident's health and wellbeing.</p> <p>Findings:</p> <p>A review of Resident 51's Change of Condition Summary, dated 3/1/24, indicated Resident 51 was discharged on [DATE] at 12 p.m. to home, with son. The nurse documented she went over Resident 51's discharge medications with Resident 51 and Resident 51's son and gave them a copy of the medications Resident 51 was to continue. The physician discharge order, nurse's Discharge Assessment and the physician's Discharge Summary Report were not located in Resident 51's medical record.</p> <p>During an interview on 6/12/24 at 10:26 a.m., the Business Office Manager stated Resident 51 wanted to go home and was discharged to home on 3/1/24. When asked where Resident 51's physician discharge order was located, the Business Office Manager stated she would go get it in Resident 51's hard copy located in the Medical Records Office.</p> <p>During an interview on 6/12/24 at 11:16 a.m., the Business Office Manager stated she could not find Resident 51's discharge order. The Business Office Manager was asked if Resident 51's physician had completed a Physician Discharge Summary. The Business Office Manager stated she would go look for both documents.</p> <p>During an interview on 6/12/24 at 6:10 p.m., the Administrator and the Business Office Manager stated the physician order for Resident 51 to be discharged to home was not written by the nurse. The Discharge Order could not be found. The Physician Discharge Summary report could not be found as of yet either.</p> <p>During an interview on 6/13/24 at 6:02 p.m., the Administrator stated there was no Discharge Order written for Resident 51 and Resident's 51's physician did not complete a Physician Discharge Summary report on Resident 51.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/14/24 at 11:30 a.m., the Administrator stated she looked one more time and could not locate a Discharge Order for Resident 51, indicating Resident 51's physician discharged Resident 51 to home, and the Administrator could not find a Physician Discharge Summary report. The Administrator gave a partial Discharge Assessment completed by the nurse indicating Resident 51 went home with his son, who was going to be his caregiver. The Discharge Assessment was incomplete and there was no signature from the resident and/or responsible party indicating all discharge instructions were discussed including medications to continue and if a list of medications was given to Resident 51 or his responsible party.</p> <p>The facility Policy/Procedure titled, Transfer and Discharge, revised 12/1/21, indicated: Purpose: To ensure that adequate preparation and assistance is provided to residents prior to transfer or discharge from the Facility. Policy: I. Social Services Staff will participate in assisting the resident with transfers and discharges, and preparing the Discharge Summary and post discharge plan of care/discharge instructions. II. Social Services Staff will conduct a Discharge Planning Assessment, develop a post discharge plan of care, and will help orient the resident to the impending discharge. Procedure: . F. If the IDT (Interdisciplinary) team and the Attending Physician determine that the resident may be appropriate for discharge, Social Services Staff will coordinate the discussion of discharge with IDT, the resident, and the responsible party . The Discharge Planning Assessment will be filed in the resident's medical record .</p> <p>The facility job description titled, Charge Nurse, undated, indicated: . General Duties and Responsibilities: Clinical: o Complete all required record keeping forms/ charts upon the resident's admission, discharge, transfer, etc. File in the resident's chart and/ or forward to the appropriate department. o Receive verbal orders from attending/ alternate physician and transcribe the physician's order sheet .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS-a resident assessment and care screening tool) for one of 23 sampled residents (Resident 12) under Section K (Swallowing/Nutritional Status), by not indicating Resident 12 was on a physician-prescribed weight loss plan. This had the potential to cause errors in Resident 12's medical treatment in order for Resident 12 to maintain an ideal physician direct weight loss recommendation order below 200 pounds (160-190 pounds) and an appropriate care plan with the necessary interventions to address nutrition. This could have further caused increased debilitating conditions, affecting Resident 12's health and quality of life.</p> <p>Findings:</p> <p>A review of Resident 12's Admission Record indicated Resident 12 was admitted on [DATE], with a diagnosis that included paranoid schizophrenia (a mental disorder) and hallucinations (seeing, feeling, or hearing something that isn't there), chronic pain, borderline personality disorder (a mental illness), altered mental status (a disruption in how your brain works that causes a change in behavior), amongst others.</p> <p>A review of Resident 12's Annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 5/15/24, indicated Resident 12 was severely cognitively impaired (issues with memory, reasoning, decision making). Section K: Swallowing/Nutritional Status, indicated Resident 12 weighed 180 pounds, had lost 5% or more in the last month or 10% or more in the last six months, and resident was not on a physician-prescribed weight-loss regimen.</p> <p>A review of Resident 12's Order Summary Report, dated 6/19/24, indicated the following order: MD (Doctor of Medicine: physician) directed weight loss recommendation from RD (Registered Dietician). Current BMI (Body Mass Index: BMI screens for weight categories that may lead to health problems, BMI ranging from 18.5 to 24.9 was a healthy weight range) was 26.9 for his height and weight. Ideal weight below 200 lbs., (160-190 lbs.), order date 2/21/23.</p> <p>A review of Resident 12's Potential Nutritional Risk care plan, revision on 5/9/24 by the RD, indicated, Focus: weight loss past 12 months, desirable likely resident meal consumption, diuresis (an increase in the amount of urine made by the kidney and passed by the body), and per MD: weight goal 160-190 lbs. Current BMI 28.2. Diet No Added Salt (NAS, regular texture and thin liquids. Supplement: Health shake three times per day. Goals included weight goal: 160-190 lbs. per MD, initiated 5/9/24 by the RD.</p> <p>A Review of Resident 12's Skin and Weight Review' dated 3/21/24, 3/29/24, 4/5/24, and 4/11/24, under the Clinical section completed by the ADON (Assisted Director of Nursing), indicated Resident 12 had a Significant Weight Loss, but his weight was 175.9-180.6, which was within the MD directed weight loss recommendation from the RD and care planned.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 6/13/24 at 3:42 pm., the RD stated she did a Weight Variance meeting with the ADON and the Dietary Manager every Wednesday at 1 p.m. They looked over weekly and monthly weight concerns. The RD stated the MDS Coordinator was not involved with Section K of the MDS, the Dietary Manager completed Section K of the MDS. It was pointed out to the RD Section K0300: Weight Loss was coded wrong. Resident 12 was on a physician weight loss regimen with an ideal weight of 160-190 lbs., but Resident 12's Annual MDS, dated [DATE], under Weight Loss, was coded as a two, Yes, not on physician-prescribed weight-loss regimen when it should have been coded as a one, Yes, on physician-prescribed weight-loss regimen.</p> <p>During a phone interview on 6/18/24 at 10:45 a.m., the RD stated she reviewed the residents' weight gain and weight loss issues with the Dietary Manager. The RD stated many of the residents' weight gain or loss issues had been coded wrong on their MDS such as Resident 12's Annual MDS, dated [DATE], which had indicated Resident 12's weight loss was not physician prescribed when it was physician prescribed. The RD stated a quarterly care conference took place with the Dietary Manager, MDS Coordinator, and the ADON, who assisted with Section K of the MDS. The RD stated the MDS Coordinator was not responsible for completing Section K of the MDS, the Dietary Manager completed Section K. The MDS Coordinator would double check to make sure Section K was completed, but not for accuracy.</p> <p>During an interview on 6/19/24 at 8:45 a.m., the ADON stated she was not familiar with the MDS. The ADON stated the Dietary Manager filled out Section K: Swallowing and Nutritional Status section of the MDS. During an interview on 6/19/24 at 1:25 p.m., the Administrator stated the DON's (Director of Nursing) signature on the last page of the MDS was verifying the MDS Assessment was completed, but not for accuracy per the RAI (Resident Assessment Instrument) manual.</p> <p>The facility job description titled, Dietary Consultant Service Agreement, dated 7/17/23, indicated, . Appendix A: Dietary Consultant Services: . 2. Provide consultation to medical, nursing, and other professional staff of Facility regarding dietary needs of Facility's residents, contribute pertinent information to interdisciplinary care plans, and plan and implement dietary programs.</p> <p>3. Review nutritional documentation on all new resident admissions, residents with decubitus ulcers, residents with significant weight losses/gains, residents experiencing acute episodes and residents who require tube feedings for nutritional support .</p> <p>A review of the facility job description titled, Director of Nutritional Services, undated, there was no indication one of the Dietary Manager's Principal Responsibilities: Clinical Area was completing Section K (Swallowing/Nutritional Status) of the residents' MDS.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27532</p> <p>5. During initial tour and interview on 6/10/24, at 10:28 AM, Resident 127 was in bed with O2 via nasal canula dispensing oxygen at 2 LPM. There was no label on the oxygen tubing.</p> <p>During an observation on 6/10/24, at 5:25 PM, Resident 127 was seated in her wheelchair in the hallway across the nurses' station without oxygenation.</p> <p>During an observation on 6/12/24, at 12:20 PM, Resident 127 was not in her room, but her O2 concentrator continued dispensing O2 at 2LPM with the oxygen tubing and nasal canula lying on top of the bed cover.</p> <p>A review of Resident 127's Change of Condition Summary dated 6/7/24, indicated she had shortness of breathing (SOB) and had an O2 saturation of 77%.</p> <p>A review of the Physician orders dated 6/7/24, indicated Oxygen at 2-3 LPM via NC to keep O2 saturation above 92 %, check O2 saturation every shift, change oxygen tubing, humidifier bottle &amp; clean filter as needed and one time a day every Sunday for oxygen therapy.</p> <p>Review of Resident 127's medical record indicated a care plan to manage her oxygen administration and monitor her condition was not developed for her shortness of breath, low O2 saturation on 6/7/24 when she had a change of condition.</p> <p>The Facility Policy &amp; Procedure titled, Care Planning, revised 11/2021, indicated: Purpose: To ensure that a comprehensive resident centered care plan is developed for each resident. Policy: It is the policy of this Facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial wellbeing. Procedure: I. A Licensed Nurse and/or other Interdisciplinary Team (IDT) In addition, a Care Plan may be initiated upon identification of a change of condition and/or any new needs. II. periodically reviewed and revised by IDT at the following intervals: i. Onset of new problems; ii. Change of condition; . vi. And vii. Other times as appropriate or necessary . V. The resident centered care plan will describe but not be limited to the following: A. Goals for the highest level of function the resident may be expected to attain .</p> <p>The facility job description titled, Medicare/MDS Coordinator, undated, indicated: . General Duties and Responsibilities: Clinical - . *Coordinates development, implementation and evaluation of plan of care .</p> <p>35842</p> <p>Based on interview, and record review, the facility failed to have an individualized care plan for four of 23 sampled residents (Resident 12, 33, 227 and 127) when:</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Resident 12 was not care planned for aspiration precautions after choking on a meatball and the speech therapist (SP) had posted instructions on the wall next to Resident 12's bed with recommendations to prevent Resident 12 from choking again,</p> <p>2. Resident 33 was not care planned for a diagnosis of acute and chronic respiratory failure with an order for oxygen (O2) at two liters to keep Resident 33's O2 saturation (sat: a measure of how much oxygen is circulating in your blood) above 91%,</p> <p>3. Resident 33 was not care planned for Risk of Constipation when Resident 33's electronic medical record under the bowel movement (BM) task indicated Resident 33 had not had a BM multiple times four or more days (anywhere from five to 15 days),</p> <p>4. Resident 227 was not care planned for Risk for Falls when her admission Fall Risk Assessment indicated Resident 227 was moderately at risk for falls and after Resident 227 fell on day two of her admission nor was Resident 227 care planned for Falls after Resident 227 fell two weeks later, and</p> <p>5. Resident 127 was not cared planned for an episode of shortness of breath and low oxygen saturation with a physician order for oxygen at 2-3 liters per minute (O2 at 2-3 L/min) via nasal cannula to keep oxygen saturation above 92%.</p> <p>The lack of care plans had the potential for direct care staff not to monitor, treat, and reassess and/or prevent:</p> <p>1. Resident 12 not being supervised closely and positioned properly while eating in bed, which could have led to him choking and even aspirating leading to further medical decline, hospitalization and even death,</p> <p>2. Resident 33's not receiving required oxygen to keep saturation above 91%, and Resident 33's abdomen feeling full, bloated, and in pain, hard stools causing hemorrhoids (swollen veins in your lower rectum), unexplained weight loss, amongst other health issues, which could lead to Resident 33 being hospitalized ,</p> <p>3. Resident 227 from having two more falls, which did occur two weeks later and had the potential to cause serious injury, hospitalization , and even death.</p> <p>4. This failure had the potential for Resident 127 to have excessive oxygen administration and poisoning resulting to drying of nasal and upper airway, coughing, trouble breathing, convulsions, amnesia, lung damage, or slow her breathing and heart rate to dangerous levels, or worse, death.</p> <p>Findings:</p> <p>1. A review of Resident 12's Admission Record indicated Resident 12 was admitted on [DATE], with a diagnosis that included paranoid schizophrenia (a mental disorder), chronic pain, borderline personality disorder (a mental illness), altered mental status (change in cognition), gastro-esophageal reflux disease without esophagitis (when acid flows back from the stomach into the esophagus but no inflammation of the esophagitis), amongst others.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 12's Annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 5/15/24, indicated Resident 12 was severely cognitively impaired (serious issues with memory, reasoning and decision making).</p> <p>A review of Resident 12's Alert Note, dated 11/13/2023, indicated: Resident 12 unable to swallow food at lunch, meatball became lodged in mouth and resident requires staff assist to pull from mouth. A ST (Speech Therapist's) Evaluation and Treatment was ordered after episode.</p> <p>A review of Resident 12's ST Evaluation, dated 11/17/23, indicated the ST tested Resident 12's swallowing/food intake abilities. ST indicated she posted oral intake (food and beverage) management requirements at Resident 12's bedside and communicated to nursing.</p> <p>A review of Resident 12's Comprehensive care plan had no Risk for Choking/Aspiration (food or liquid enters a person's airway and eventually the lungs by accident, which could lead to serious health issues such as pneumonia and chronic lung scarring) Precautions care plan initiated after Resident 12 choked on a meatball on 11/13/23 nor after the ST's evaluation, dated 11/17/23, for swallowing/food intake abilities.</p> <p>During a concurrent observation and review of the ST's oral intake instructions posted on the back wall, right of Resident 12's headboard on 6/10/24 at 1:01 p.m., the ST instructions were as follows: 1. Complete meal set-up: open drinks, add condiments, and cut foods, 2. Frequent Spot Checks required to ensure safety, 3. Diagram showing 90 degree position (seated upright with one's spine straight) Resident 12 needed to be positioned to eat his meals, and 4. Note indicating if Resident 12 refused his head of bed upright hold solid foods until Resident 12 allows upright position. Resident 12 was positioned approximately 65 degrees while feeding himself lunch. Resident 12's meal tray was placed on his overbed table, which was in front of him, but Resident 12 had to reach his food because Resident 12's head of bed was not positioned 90 degrees. No nurse or CNA (Certified Nursing Assistant) was observed Spot Checking Resident 12 to ensure safety, making sure Resident 12 was not having difficulties with swallowing his food.</p> <p>During an observation on 6/10/24 a 01:08 p.m., no Nurse or CNA checked on Resident 12 per the ST instructions while Resident 12 continued feeding himself with his right hand.</p> <p>During an observation on 6/10/24 at 1:12 p.m., no CNA or nurse checked on Resident 12 while he continued feeding himself his lunch. Resident 12 was drifting off to sleep with his fork in his hand.</p> <p>During an observation on 6/10/24 at 1:14 p.m., Resident 12 was still feeding himself and no nurse or CNA checked on Resident 12 per ST instructions: Frequent Spot Checks required to ensure safety. Another surveyor observed Resident 12's eating position and indicated Resident 12 was at a 60-degree position while eating his lunch in bed.</p> <p>During a phone interview on 6/13/24 at 8:55 a.m., the ST stated Resident 12's swallow evaluation was a long time ago. The ST stated it may have been Resident 12 had a choking episode and those were instructions to be followed to prevent Resident 12 from choking on his food while he fed himself. The ST stated if Resident 12 could not tolerate his bed being positioned at 90 degrees while feeding himself, Resident 12's nurse or CNA should pop in to make sure he is tolerating feeding himself and not choking.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/19/24 at 12:03 p.m., the MDS Coordinator had been asked why Resident 12 did not have a Risk for Choking/Aspiration care plan initiated after he choked on a meatball at lunchtime on 11/13/23 or after the ST's posted oral intake precautions instructions at Resident 12's bedside. The MDS Coordinator stated Resident 12's Choking care plan was the ST's evaluation of Resident 12 and Resident 12 did not need an At Risk for Choking/Aspiration care plan initiated in his Comprehensive Care Plan. When the MDS Coordinator was asked again, if a resident had a choking episode, a Risk for Choking/Aspiration care plan would not have to be initiated in the resident's Comprehensive Care Plan, the MDS Coordinator stated that was correct. The MDS Coordinator stated the ST had created a paper care plan for Resident 12 that could be print off and/or the nurses could find the ST care plan in Resident 12's electronic medical record. The MDS Coordinator did not print off Resident 12's ST care plan from Resident 12's electronic medical record when she was being interviewed. The MDS Coordinator had to go to the Rehabilitation Department to find Resident 12's ST care plan started by the ST after she evaluated Resident 12 on 11/17/23.</p> <p>During an interview on 6/19/24 at 1:25 p.m., the Administrator stated if a resident had a choking episode like Resident 12 did on 11/13/23, a short-term care plan should have been started regarding the episode and then a long term care plan should have been initiated on Resident 12's Comprehensive Care Plan after the ST completed Resident 12's swallowing evaluation on 11/17/23.</p> <p>2. A review of Resident 33's Admission Record indicated Resident 33 was admitted on [DATE], with a diagnosis including stroke, hemiplegia (paralysis that affects only one side of the body) affecting the left side, dysphagia (difficulty in swallowing), acute respiratory failure with hypercapnia (too much carbon dioxide in one's blood), acute respiratory failure with hypoxia (not enough oxygen in one's blood), chronic respiratory failure, delusional disorder (a mental disorder), bipolar disorder (a mental disorder), bed confinement status, morbid (severe) obesity, amongst others.</p> <p>A review of Resident 33's Quarterly MDS, dated [DATE], indicated Resident 33 was severely cognitive impaired (never/rarely made decisions), Section I - Active Diagnosis indicated Resident 33 had a diagnosis of Respiratory Failure, and Section O - Special Treatments and Programs, indicated Resident 33 was on Oxygen (O2) therapy.</p> <p>A review of Resident 33's Order Summary Report, dated 6/20/24, indicated O2 at 2 Liters (L) per minute to keep Sats (Saturation: measures how much oxygen is in the blood) above 91% every shift for O2 Therapy per MD (Doctor of Medicine). Resident 33 can remove O2 if she wants but must be maintained for unverbilized drops in O2 Sat levels, start date 3/28/23 and Shortness of Breath Monitoring every shift for O2 Therapy, start date 12/8/23.</p> <p>During a concurrent interview and electronic medical record review on 6/14/24 at 11:30 a.m., the Administrator stated she could not find an At Risk for Respiratory Failure/ Oxygen Therapy care plan initiated for Resident 33. The Administrator stated an At Risk for Respiratory Failure/ Oxygen Therapy care plan should have been started when Resident 33 started O2 Therapy. The Administrator stated the MDS Coordinator or Charge nurse should have started a care plan. The Administrator stated any nurse on the floor could have initiated Resident 33's At Risk for Respiratory Failure/O2 Therapy care plan, with the goal of Resident 33's O2 SAT level being maintained at 91% or greater.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/19/24 at 10:15 a.m., the MDS Coordinator stated Resident 33 not having an At Risk for Respiratory Failure/O2 Therapy care plan should have been caught on Resident 33's Quarterly MDS review, dated 3/12/24 or Resident 33's IDT (Interdisciplinary Team: a group of health care professionals with various areas of expertise who work together toward the goals of their clients) meeting. The MDS Coordinator stated any nurse could have initiated Resident 33's At Risk for Respiratory Failure/O2 Therapy care plan.</p> <p>3. A review of Resident 33's Quarterly MDS, dated [DATE], indicated Resident 33's H Section: Bladder and Bowel: Always incontinent of bowel.</p> <p>A review of Resident 33's Bowel task in Resident 33's electronic medical record, dated 5/1/24 to 6/20/24, indicated on multiple occasions Resident 33 went several days without having a BM, 5/6/24-5/10/24 (five days without having a BM), 5/16/24-5/22/24 (seven days without having a BM), 5/25/24-6/8/24 (15 days without having a BM), and 6/12/24-6/18/24 (seven days without having a BM).</p> <p>A review of Resident 33's Order Summary Report, dated 6/19/24, orders indicated: 1. May implement routine bowel care three step program if no BM in three days, start date 11/28/22, 2. MOM give 30 ml by mouth as needed for constipation no BM times two days, start date 11/28/22, 3. Dulcolax Suppository 10 mg insert one suppository rectally as needed for constipation if MOM ineffective, if no results from suppository in 12 hours give enema, start date 11/28/22, and 4. Sodium Phosphates Enema insert 133 ml rectally every four hours as needed for constipation, start date 5/29/24.</p> <p>A review of Resident 33's MAR, dated 5/2024 and 6/2024, indicated there was no Bowel Care implemented for Resident 33 not having a BM for three days or more, 5/6/24-5/10/24 (five days without having a BM), 5/16/24-5/22/24 (seven days without having a BM), and 5/25/24-6/8/24 (15 days without having a BM), and 6/12/24-6/18/24 (seven days without having a BM). MOM 30 ml was given on 6/19/24 at 9:45 a.m. after Resident 33 had not had a BM for seven days, which indicated effective.</p> <p>During an interview on 6/19/24 at 10:11 a.m., Licensed Nurse A stated if a resident did not have a BM in three days, bowel care per physician's order should be started. Licensed Staff A stated there was a little bell symbol on the resident's electronic medical record, which the nurse could tap alerting the nurse to all the resident's issues such as no BM in three days per the Certified Nursing Assistance's charting in the resident's Plan of Care. Licensed Staff A stated the CNAs never communicate to her if their residents have not had a BM.</p> <p>During an interview on 6/19/24 at 5:20 p.m., the Administrator stated if a resident has not had a BM in three days the nurse should have given bowel care per the physician's order.</p> <p>A review of Resident 33's Comprehensive Care Plan did not have an At Risk for Constipation care plan initiated for Resident 33, who on multiple occasions did not have a BM for four or more days and no bowel care protocol was provided.</p> <p>During an interview on 6/21/24 at 12:30 p.m., the DON (Director of Nursing) stated a resident should have a BM at least every three days. The DON stated the alert residents should be able to tell their CNA (Certified Nursing Assistant) if they have not had a BM for three or more days. CNAs should tell their nurse about their residents who have gone more than three days without having a BM. The DON stated if the resident was having issues with constipation, the resident should be care planed for being at Risk for Constipation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. A review of Resident 227's Admission Record, indicated resident 227 was admitted on [DATE], with a diagnosis including cerebral infarction (stroke), difficult walking, dysphagia (difficulty in swallowing), age-related osteoporosis (causes bones to become weak and brittle), tremor (involuntary quivering movement), restless leg syndrome (an overwhelming urge to move your legs), high blood pressure, hemiplegia (paralysis), aphasia (trouble communicating or understanding), osteoarthritis (wear and tear disease on the joints in one's hands, legs, knees, hips, lower back and neck causing pain and stiffness), amongst others.</p> <p>A review of Resident 227's admission Fall Risk Evaluation, dated 5/10/24, indicated Resident 227 was at moderate risk for falls.</p> <p>Fall 1</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/11/24 at 1:30 a.m., indicated Resident 227 had an unwitnessed fall in the bathroom, which caused a skin tear to Resident 227's right arm below her elbow. A review of Resident 227's care plan indicated no Fall care plan was implemented after Resident 227's fall on 5/11/24.</p> <p>A review of Resident 227's Admission MDS, dated [DATE], indicated Resident 227 had a BIMS (Brief Interview of Mental Status) score of 3, which meant Resident 227's cognitive skills for decision making was severely impaired. Section J - Health Condition indicated Resident 227 had a fall in the last month prior to admission/entry or reentry into the facility and Resident 227 had a fall in the last two-six months prior to admission/entry or reentry into the facility. Section V- Care Area Assessment (CAA) Summary of Resident 227's MDS, indicated the Care Area for Falls triggered.</p> <p>Fall 2</p> <p>A review of Resident 227's Change of Condition Summary dated 5/26/24, indicated Resident 227 had an unwitnessed fall at 6 a.m. A Certified Nursing Assistant (CNA) found Resident 227 on the floor in the bathroom and alerted Resident 227's nurse. An assessment was performed. Resident 227 was complaining of pain to her right arm and Resident 227 had a small bump assessed at the back of her head. Resident 227 did not want to go to hospital. A review of Resident 227's care plan indicated no Fall care plan was implemented after Resident 227's second fall.</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/26/24 at 10:33 p.m., indicated Resident 227 went to the hospital to be assessed for further evaluation after falling that morning at 6 a.m.</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/27/24 at 1:53 a.m., indicated Resident 227 had gone to the hospital to have her right shoulder checked. Resident 227 returned from the hospital via a non-emergency ambulance at 12:25 a.m. with a diagnosis Contusion of Right Shoulder. The Administrator, DON, and Resident 227's physician was notified about the diagnosis from the 5/26/24 post fall.</p> <p>Fall 3</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/28/24 at</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6:39 a.m., indicated the nurse was notified by a staff employee Resident 227 was on the floor next to her bed. The nurse found Resident 227 in a semi sitting position, an assessment was performed, a minor skin tear noted at Resident 227's left forearm, and no other injuries noted. Resident 227 had denied any pain. The facility unwitnessed fall protocol was implemented, which included neuro checks for 72 hours.</p> <p>A review of Resident's 227's care plan, indicated Resident 227 had an Fall care plan, initiated 5/28/24 for the actual fall. Focus: (Specified: No Injury, minor injury, serious injury), poor balance, and unsteady gait. Goal: Resident 227 will resume usual activities without further incident through the review date. Interventions: Neuro-checks times 72 hours. No other interventions were implemented to minimize Resident 227's risk for falling again. Note: Resident 227 did have a minor skin tear after the 5/28/24 fall. An At Risk for Fall care plan did not get initiated for Resident 227 after she fell three times in two weeks.</p> <p>A review of Resident 227's Fall Risk Evaluations, dated 5/26/24 and 5/28/24, both indicated Resident 227 was at moderate risk for falls.</p> <p>A review of Resident 227's Fall Risk care plan, initiated 6/9/24, indicated, Focus: Resident 227 was at risk for falls related to hemiplegia (paralysis) and hemiparesis (muscle weakness). No goals and interventions were initiated in order to maintain and maximize Resident 227's quality of life, while minimizing Resident's risk of having another fall to prevent another injury.</p> <p>During an interview on 6/13/24 at 12:05 p.m., the DON was asked if the facility had a Fall Committee, and the DON stated the facility did not have a Fall Committee. The DON stated Risk Management would document about the fall and 72-hour charting would take place (monitoring the resident post fall). The DON stated falls were talked about at the resident's care conference and at the start of shift huddles (change of shift report given by the off going nurses).</p> <p>During an interview on 6/14/24 at 11:30 a.m., the Administrator was asked why Resident 227 had not had an At Risk for Fall care plan initiated after her first fall. The Administrator did not answer the question and stated residents at risk for falls had a Humpty Dumpty card posted next to the residents' room name placard. The Administrator stated staff didn't know which resident in the room was at risk for falls, but the staff was aware that one or more residents in the room were at risk for falls. The Administrator stated the nurses and CNAs were also notified which residents were at risk for falls during the change of shift huddle.</p> <p>During a concurrent interview and record review, dated 6/19/24 at 10:20 a.m., the MDS Coordinator stated a resident who was at risk for falls should have had an At Risk for Falls care plan prioritized. The MDS Coordinator reviewed Resident 227's care plan and confirmed, Resident 227 did not have a care plan initiated after her first fall. The MDS Coordinator stated the nurse should have started an At Risk for Fall care plan after Resident 227's first fall occurred.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27532</p> <p>35842</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure their policy was followed and comprehensive care plans for 2 of 24 sampled residents (Resident 28, Resident 51) were reviewed and revised after every fall at the facility. This failure resulted in the resident's care not being reviewed by the interdisciplinary team to mitigate additional falls, and had the potential to result in low quality of care, harm and death to the residents involved.</p> <p>Findings:</p> <p>Resident 28</p> <p>Record review indicated Resident 28 was admitted to the facility on [DATE] with medical diagnoses including History of Falling (History of having suffered falls, which may indicate increased risk for future falls), Difficulty in Walking, and Muscle Weakness, according to the facility Face Sheet (Facility Demographic).</p> <p>1st Fall:</p> <p>Record review of Resident 28's progress note dated 1/18/24 at 12:45 a.m., indicated, Responded to resident's room after a CNA (Certified Nursing Assistant) stated that the resident was observed on the floor. Resident was sitting on her bottom on the floor at the foot of her bed.</p> <p>During a concurrent interview and record review with the Director of Staff Development (DSD) on 6/20/24 at 5:10 p.m., she stated that after the fall on 6/18/24, a care plan for falls had been developed with the following interventions, 72 hour Neuro (Neurological assessments) started (The DON was unable to find neurological checks for this fall, above) .[name of hospital] evaluation offered and refused .Wound care provided. No interventions were present in the care plan for increased supervision of Resident 28 to prevent further falls.</p> <p>2nd Fall</p> <p>Record review of a nursing progress note dated 2/12/24 at 12:44 p.m., indicated, Resident was observed, sitting on the ground with her arm and elbow stuck in the bed rail of the bed. The resident stated she just slipped trying to get up causing her arm to get stuck in the bed rail. An abrasion is present on her right elbow.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/12/24. No new interventions were added, included increased supervision.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3rd Fall</p> <p>Record review of a nursing progress note dated 2/16/24 at 3:05 p.m., stated, resident was observed on the floor in her bathroom, when asked what happened the resident stated that she slipped in water or something and landed on her knee.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/16/24. No new interventions were added, included increased supervision.</p> <p>4th Fall</p> <p>Record review of a facility report titled, #2214 Fall, dated 2/24/24 (No time documented) indicated, Resident was observed sitting on her bottom at bed side. Her bed was in the lowest position and she appeared to slid off the bed onto the floor when trying to get up.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/16/24. There were no new interventions, including increased supervision.</p> <p>5th Fall</p> <p>Record review of a progress note dated 3/17/24 at 3:15 a.m., stated, Resident [Resident 28] was observed sitting on her bottom on the floor by the side of the bed. Resident stated that she slid right of the bed.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 3/17/24. The care plan for falls did get revised on 4/02/24 (16 days after the fall on 3/17/24) with the following intervention, Hourly Rounding.</p> <p>6th Fall</p> <p>Record review of a progress note dated 4/04/24 at 3:39 p.m., indicated, called to resident room STAT (Immediately), upon getting to room resident noted on the floor in the sitting position .resident stated she was standing eating her Peanut Butter and jelly sandwich, then fell to the ground hitting her Right elbow.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 4/04/24. No new interventions were added, including increased supervision.</p> <p>7th Fall</p> <p>Record review of a progress note dated 5/10/24 at 9:39 p.m., indicated, Resident had a fall this shift around 9pm. Observed on her R (Right) side on the [NAME] hallway with only one shoe on. Voiced that she lost her balance.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 4/04/24. No new interventions were added, including increased supervision.</p> <p>8th Fall</p> <p>Record review of Resident 28's progress note dated 5/13/24 at 9:53 p.m., indicated, resident had an unwitnessed fall in her room. Resident was observed on the ground outside her bathroom.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/13/24. No new interventions were added, including increased supervision.</p> <p>9th Fall</p> <p>Record review of a progress note dated 5/19/24 at 5:48 p.m., indicated, This writer went in to check on resident and observed the resident with her RT (Right) knee on the ground holding on to her wheeled walker trying to come to a standing position. When resident was asked what happened she stated that she had fallen like that multiple time today.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/19/24. No new interventions were added, including increased supervision.</p> <p>10th Fall</p> <p>Record review of a progress note dated 5/26/24 at 1:25 p.m., indicated, Resident [Resident 28] had a fall this afternoon. Found on the floor lying in front of her bathroom. Stated that she lost her balance.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/26/24. No new interventions were added, including increased supervision.</p> <p>11th Fall</p> <p>Record review of a progress note dated 5/31/24 at 8:07 a.m. indicated, Responded to a nurse stat. Resident was laying on her stomach on the floor with her arms out in front of her and her wheeled walker out in front of her. Resident stated that she fell to her knees and then the walker kept going without her.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/26/24. No new interventions were added, including increased supervision.</p> <p>12th Fall, with Major Injury</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a progress note dated 6/12/24 at 4:25 a.m., indicated, 0320 (3:20 a.m.) CNA (Certified Nursing Assistant) found resident sitting on floor, stat (Immediately) called resident stated she slipped out her wheelchair onto the floor .resident c/o (Complained of) right hip pain 8/10 (Pain level of 8 out of 10, where 0 signifies no pain, and 10 is the worst pain experienced in a person's lifetime. A level of 8 out of 10 indicates severe pain) has history of right hip FX (Fracture), sent resident out to [hospital] for assessment.</p> <p>Record review of the acute care hospital after visit summary dated 6/17/24 (No time documented) indicated Resident 28 was diagnosed with a fracture of the right femoral neck on 6/12/24 (After the fall on 6/12/24 at 3:20 a.m.) This acute care hospital after visit summary indicated Resident 28 underwent surgery to repair the fracture to the right hip.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated the care plan for falls was updated on 6/16/24 with the following interventions, continue to offer safety equipment and devices in the event resident changes her preferences .encourage resident to make safe choices to minimize risk for injury .patient education. There was no mention of increased supervision. The DSD was unable to find a care plan for care of the right hip fracture.</p> <p>Record review of the facility policy titled, Fall Management Program, last revised on February 18, 2022, indicated, Following each resident fall, the Licensed Nurse will perform a Post-Fall Assessment, and update, initiate or revise a Plan of Care .The IDT will summarize conclusions after their review of the fall and circumstances surrounding the fall on an IDT note. The plan of care will also be reviewed, and the care will be revised as necessary in an effort to prevent further falls with major injury.</p> <p>Resident 51</p> <p>During a concurrent interview and observation on 6/11/24, at 9:24 AM, Resident 51 stated he had a fall a week ago. His wife, whom he shared the room, stated he had a bad dream and threw himself out of bed. There were no floor mats noted around his bed.</p> <p>A review of Resident 51's admission MDS dated [DATE] indicated he had moderately impaired cognition with a BIMS (Brief Interview of Mental Status) score of 9. He had limited mobility on one side requiring moderate assistance with mobility and he had falls in the past two to six months.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 51's records indicated in his recent fall risk evaluation dated 1/24/24 that he was a high fall risk with a score of 18. His care plans for his recent admission on 4/30/24 indicated he had unwitnessed falls without injuries on 1/30/24 and 2/2/24. Interventions after the first fall was Ensure call light is within reach. Additional interventions after the second fall were: 72-hours neurological checks, and bed will remain in the lowest position. An alert charting dated 1/31/24 indicated: Residents bed in lowest position, fall mat in place, call light in hand. No delayed injuries or complaint of pain or discomfort. An Interdisciplinary team notes on fall dated 1/24/24 indicated, immediate intervention included bed in low position, fall mat next to bed, urinary analysis done due to increased confusion, neurological assessment, and vitals. Resident 51's records did not indicate a fall risk assessment was done after the first fall to identify the cause of fall and add interventions to the care plan. Resident 51's care plan was not updated to include the fall mat, frequent rounding or checks and other personalized interventions to prevent falls and possible injuries in the future. A look back at Resident 51's original admission on 5/11/23 when he was assessed at moderate risk for fall, did not indicate a care plan was developed to prevent falls. Resident 51's care plan on falls did not include preventative interventions, his fall care plan was only developed after he fell on [DATE].</p> <p>Record review of the facility policy titled, Care Planning, last revised on 11/2021, indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial wellbeing .The Care Plan will be completed within seven (7) days after completion of the RAI (Resident Assessment Instrument-A data gathering system of each resident's strengths and needs, which must be addressed in an individualized care plan), Comprehensive Admission Assessment, and periodically reviewed and revised by IDT (Interdisciplinary team) at the following intervals: i. Onset of new problems; ii. Change of condition; iii. Quarterly.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on interview and record review, the facility failed to monitor and follow the physician orders and facility's Protocol for Constipation for two of 23 sampled residents, (Resident 29 and Resident 33), leading to Resident 29 and Resident 33 not having a bowel movement (BM) for several days. This had the potential for Resident 29's and 33's abdomen feeling full, bloated, and in pain, hard stools causing hemorrhoids (swollen veins in your lower rectum), unexplained weight loss, amongst other health issues, which could lead to Resident 29 and Resident 33 being hospitalized .</p> <p>Findings:</p> <p>1. A review of Resident 29's Administration Record, indicated Resident 29 was admitted [DATE], with a diagnosis of sequelae of cerebral infarction (stroke caused by disruption of blood flow to the brain), convulsions (involuntary contracture of the muscles), feeding difficulties, muscle weakness, blindness right and left eye, dementia (more confused and forgetful), psychotic disturbances (a mental disorder), anxiety, major depression, and hemiplegia (paralysis of one side of the body), amongst others.</p> <p>A review of Resident 29's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/12/24, indicated Resident 29 could not complete a BIMS (Brief Interview of Mental Status) exam. Resident 29 had memory problems and cognitive skills for daily decision making were severely impaired; one upper extremity and both lower extremities had functional limitation of range of motion, and Section H: Bladder and Bowel indicated Resident 29 was incontinent of bladder and stool all the time.</p> <p>A review of Resident 29's Bowel task in Resident 29's electronic medical record, dated 5/1/24 to 6/20/24, indicated on multiple occasions Resident 29 went more than three days without having a BM. 5/12/24-5/18/24 (six days without a BM), 5/26/24-5/31/24 (six days without a BM) and 6/2/24-6/8/24 (seven days without a BM).</p> <p>A review of Resident 29's Order Summary Report, dated 6/19/24, orders indicated: 1. May implement routine bowel care three step program if no BM in three days, order date 9/1/21, 2. Notify MD (Doctor of Medicine) if no BM times four days, order date 9/1/21, 3. MOM (Milk of Magnesia) give 30 ml (milliliter) by mouth as needed for constipation. Give 30 ml every day if needed. If no results within 12 hours give suppository, start date 9/2/21, 4. Dulcolax Suppository 10 mg (milligrams) insert one suppository rectally every day as needed for constipation. Administer one suppository per rectally every day as needed if no BM times three days. If no results from suppository in 12 hours give enema, start day, 9/2/21, and 5. Fleet enema 7-19gm (grams)/118 ml (Sodium Phosphate) insert application rectally as needed for constipation. Administer once daily as needed if Dulcolax is not affective. If no results within two hours of enema notify provider, start date 9/2/21. Resident 29 had two routine medications for constipation: 1. MOM give 30 ml by mouth in the evening every Sunday for constipation, start date 9/5/21 and 2. Polyethylene Glycol Powder, give 17 grams by mouth one time a day for constipation, start date 9/2/21.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 29's MAR (Medication Administration Record), dated 5/2024 and 6/1/2024-6/19/24, indicated Resident 29 had her routine MOM 30 ml every Sunday at 5 p.m., 5/5/24, 5/12/24, 5/19/24, 5/26/24, 6/16/24 and refused 6/2/24 and 6/9/24. Resident 29 received Polyethylene Glycol Powder, give 17 grams by mouth every day at 8 a.m., but refused on 5/27/24, 5/28/24, 5/30/24, and only took in June on 6/7/24 and 6/18/24. A review of Resident 29's Nurses Progress Notes, dated 5/28/24-6/2/24, indicated Resident 29 was refusing medications and Resident 29's physician was aware. No documentation was noted that any other Bowel Care for constipation was implemented such as a Dulcolax suppository since Resident 29 was refusing medications by mouth at times and Resident 29 had gone several days without a BM, 5/12/24-5/18/24 (six days without a BM), 5/26/24-5/31/ (six days without a BM) and 6/2/24-6/8/24 (seven days without a BM).</p> <p>2. A review of Resident 33's Admission Record indicated Resident 33 was admitted on [DATE], with a diagnosis including stroke, hemiplegia (paralysis that affects only one side of the body) affecting the left side, dysphagia (difficulty in swallowing), delusional disorder (unshakable belief in something that's untrue), bipolar disorder (a mental disorder), bed confinement status, morbid (severe) obesity, amongst others.</p> <p>A review of Resident 33's Quarterly MDS, dated [DATE], indicated Resident 33 was severely cognitive impaired (never/rarely made decisions) and H Section: Bladder and Bowel: Always incontinent of bowel.</p> <p>A review of Resident 33's Bowel task in Resident 33's electronic medical record, dated 5/1/24 to 6/20/24, indicated on multiple occasions Resident 33 went several days without having a BM, 5/6/24-5/10/24 (five days without having a BM), 5/16/24-5/22/24 (seven days without having a BM), 5/25/24-6/8/24 (15 days without having a BM), and 6/12/24-6/18/24 (seven days without having a BM).</p> <p>A review of Resident 33's Order Summary Report, dated 6/19/24, orders indicated: 1. May implement routine bowel care three step program if no BM in three days, start date 11/28/22, 2. MOM give 30 ml by mouth as needed for constipation no BM times two days, start date 11/28/22, 3. Dulcolax Suppository 10 mg insert one suppository rectally as needed for constipation if MOM ineffective, if no results from suppository in 12 hours give enema, start date 11/28/22, and 4. Sodium Phosphates Enema insert 133 ml rectally every four hours as needed for constipation, start date 5/29/24.</p> <p>A review of Resident 33's MAR, dated 5/2024 and 6/2024, indicated there was no Bowel Care implemented for Resident 33 not having a BM for three days or more, 5/6/24-5/10/24 (five days without having a BM), 5/16/24-5/22/24 (seven days without having a BM), and 5/25/24-6/8/24 (15 days without having a BM), and 6/12/24-6/18/24 (seven days without having a BM). MOM 30 ml was given on 6/19/24 at 9:45 a.m. after Resident 33 had not had a BM for seven days, which indicated effective.</p> <p>During an interview on 6/19/24 at 10:11 a.m., Licensed Nurse A stated if a resident did not have a BM in three days, bowel care per physician's order should be started. Licensed Staff A stated there was a little bell symbol on the resident's electronic medical record, which the nurse could tap alerting the nurse to all the resident's issues such as no BM in three days per the Certified Nursing Assistance's charting in the resident's Plan of Care. Licensed Staff A stated the CNAs never communicate to her if their residents have not had a BM.</p> <p>During an interview on 6/19/24 at 5:20 p.m., the Administrator stated if a resident has not had a BM in three days the nurse should have given bowel care per the physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/21/24 at 12:30p.m., the DON (Director of Nursing) stated residents should have a BM at least every three days. Th DON stated the alert residents should be able to tell their Certified Nursing Assistances (CNAs) they have not had a BM and need a laxative. The CNAs should tell their nurse about residents not having a BM within three days. The DON stated residents having issues with having a BM should have a care plan implemented for At Risk for Constipation.</p> <p>The facility Policy and Procedure titled, Constipation Policy, revised 1/5/2024, indicated: . Purpose: Constipation is a common ailment for long-term care (LTC) patients, and laxatives are the most prescribed medications by LTC facilities. In the elderly long-term care population, up to 74% of patients receive at least one laxative per day. Policy: To reduce both the health and financial costs of constipation, it is important for long-term care facilities to establish an effective bowel care program. Procedure: . e. The effective use of laxatives: i. If the resident has not had a bowel movement within 6 shifts, the resident will be offered one or more of the following. 1. Milk of Magnesia, 2. Suppository, and 3. Enema. ii. If the resident has not had a bowel movement within 8 shifts, the licensed nurse will perform an assessment and treat as indicated. iii. Physician will be notified. iv. Documentation will be done in electric health record.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35842</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure seven of 23 sampled residents (Resident 232, Resident 14, Resident 67, Resident 4, Resident 12, Resident 20, and Resident 29) received assistance with activities of daily living (ADLs-Activities related to personal care such as showering, grooming, toileting, etc.), when:</p> <ol style="list-style-type: none"> <li>1. Resident 232 was left with a soiled disposable brief for a prolonged period of time, which damaged the skin underneath severely. This failure had the potential to result in infections and development of pressure injuries, and may have contributed to the severe pain Resident 232 suffered at the end of his life.</li> <li>2. Resident 14, who required assistance with ADLs was not provided with frequent incontinence care (Cleaning and drying of the genital areas of a resident with loss of bowel and bladder control) and repositioning. This had the potential to result in the development of pressure injuries, pain, shame, and feelings of distress and frustration.</li> <li>3. Resident 67 &amp; Resident 4, who were at risk for dehydration, were not provided drinking water. This had the potential to result in dehydration, discomfort, and feelings of frustration.</li> <li>4. Resident 12, 20, and 29, were not given two weekly scheduled showers based on the facility Shower Schedule. This resulted in residents looking unkempt, and had the potential for the residents to feel neglected and unclean, and negatively impact the resident's physical and psychosocial wellbeing.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Record review indicated Resident 232 was admitted to the facility on [DATE] with medical diagnoses including Septic Shock (A widespread infection causing organ failure and dangerously low blood pressure), according to the facility Face Sheet (Resident demographics).</li> </ol> <p>Record review of Resident 232's MDS (Minimum Data Set-An assessment tool) dated [DATE] indicated he was completely dependent on staff for toileting hygiene and personal hygiene.</p> <p>Record review of Resident 232's progress note dated [DATE] at 1:20 p.m. indicated Resident 232 would be returning to the facility from a General Acute Care Hospital (GACH) at around 1:30 p.m., on that same day.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 9:30 a.m., Family Member N stated Resident 232 was left with a soiled disposable brief for more than 48 hours after he returned to the facility from the GACH, which severely burned his skin, and caused him excruciating pain on the last days of his life. According to Family Member N, Resident 232 died within a week of returning from the GACH. Family Member N stated he discovered Resident 232 was left with the same disposable brief because in the GACH they used a different type of disposable briefs as in the facility, and two days after Resident 232 had returned to the facility from the GACH, he was still wearing the same disposable brief he came with from the GACH. According to Family Member N, staff were also supposed to swab Resident 232's mouth every twenty minutes during his final days, but they only did it about three times during a 24-hour period. Family Member N stated he called the Administration by phone to tell her what he was seeing regarding Resident 232's care, with two staff members present. Family Member N stated the Administrator lied and stated Resident 232's skin was damaged because his urinary catheter (a tube inserted into the resident's bladder to help with urination) had leaked, but the two staff members who were present with Family Member N at the time of the call, told the Administrator by phone, Resident 232's skin was damaged due to the GACH disposable diaper having been left on him for a prolonged period of time. Family Member N stated the Administrator stopped the conversation at that moment, and told the staff members that were present with him to go talk to her immediately. Family Member N stated that because of the damage to the skin caused by this disposable brief being left on the skin for a prolonged period of time, Resident 232 was miserable during his final days and in excruciating pain.</p> <p>Record review of Resident 232's ADL flow sheets for January of 2024, indicated he received incontinence care on [DATE] at 9:01 p.m., after he returned from the GACH (If he returned from the GACH at 1:30 p.m., as the progress note dated [DATE] at 1:20 p.m., indicated, Resident 232 did not receive incontinence care until 7.5 hours after he returned from the GACH). On [DATE] Resident 232 received incontinence care (according to the documentation) at 12:37 a.m. (More than 3.5 hours after the last episode), 1:59 p.m. (More than 13 hours after the last episode), and at 9:59 p.m. (8 hours after the last episode). On [DATE], the flow sheet indicated Resident 232 received incontinence care at 1:14 a.m. (More than 3 hours after the last episode), 1:59 p.m. (More than 12 hours after the last episode), and at 9:59 p.m. (8 hours after the last episode). The ADL flow sheets for [DATE] also indicated the following, Check on resident every 30 minutes and address hydration, repositioning, skin care, oral care . This flow sheet indicated that on [DATE], these services were provided at 1:14 a.m., 3:00 a.m. (More than 1.5 hours after the last episode), 4:00 a.m. (1 hour after the last episode) and hourly thereafter until 9:00 p.m. After 9:00 p.m., these services were not provided until the following day at 1:47 a.m. (More than 3.5 hours after the last episode).</p> <p>Record review of a facility document titled, Admission Nursing Evaluation, dated [DATE] at 2:26 p.m., indicated that after Resident 232 returned from the GACH, his only skin injuries were on the chest area, where a bruise and skin tear were noted.</p> <p>Record review of a facility document titled, Weekly Skin check and Wound Assessment, dated [DATE] at 12:28 p.m., indicated Resident 232 had developed, Redness with coccyx (The lower back area, at the bottom of the spine) as well .Bilateral (Both) legs discolored purple in color.</p> <p>Record review of a progress note dated [DATE] at 7:15 p.m., indicated Resident 232 passed away on [DATE] at 6:30 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 10:06 a.m., the Director of Nursing (DON) confirmed Resident 232's brief was left soiled for an extended period of time which damaged the skin, after his hospital visit. The DON stated not knowing exactly how many hours the disposable brief was left on.</p> <p>Record review of Resident 232's Medication Administration Record for January of 2024, indicated his pain level on [DATE] between 2:00 p.m. and 10:00 p.m., was a ,d+[DATE] (Pain scale where 0 signifies no pain, and 10 is the worst pain experienced during a person's lifetime. A pain level of 1 to 3 means mild pain; 4 to 7 is considered moderate pain; 8 and above is severe pain). On [DATE] his pain was documented as , d+[DATE] between 2:00 p.m. to 6:00 a.m. On [DATE] Resident 232's pain was documented as ,d+[DATE] from 6:00 a.m. to 2:00 p.m., ,d+[DATE] between 2:00 p.m., and 10:00 p.m., and ,d+[DATE] between 10:00 p. m. to 6:00 a.m. This indicated Resident 232 experienced moderate to severe pain on his final days at the facility.</p> <p>During a phone interview with Anonymous Witness O on [DATE] at 4:15 p.m., they stated having worked for the facility, and taken care of Resident 232 before he passed away. Anonymous Witness O stated that when Resident 232 returned from the GACH (on [DATE]) his disposable brief was not changed for at least 12 hours. Anonymous Witness O stated Resident 232's face looked gray and his mouth did not appear to have been swabbed. Anonymous Witness O stated Resident 232's skin on his perianal area was beyond excoriated, every time they tried to wipe it would bleed, from the damage suffered for having left the disposable brief on his body for too long. Anonymous Witness O stated Resident 232 developed sores on his testicles and open wounds on his bottom. Anonymous Witness O corroborated Family Member N's story that two staff members noted the disposable brief had been left on Resident 232's body for an extended period of time, and notified Family Member N of this.</p> <p>2. Record review indicated Resident 14 was admitted to the facility on [DATE] with medical diagnoses including Obesity, and Urinary Tract Infections, according to the facility Face Sheet.</p> <p>Record review of Resident 14's MDS (Minimum Data Sheet-An assessment tool) dated [DATE] indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 15, which indicated her cognition was intact (A score of ,d+[DATE] indicates the cognition is severely impaired, ,d+[DATE] indicates the cognition is moderately impaired, and ,d+[DATE] indicates the cognition is intact). Record review of Resident 14's MDS dated [DATE] also indicated Resident 14 was completely dependent on staff for toileting hygiene and required maximal assistance with rolling left and right in bed.</p> <p>Record review of Resident 14's care plan for incontinence care initiated on [DATE] indicated she was incontinent of bowel and bladder.</p> <p>During an interview on [DATE] at 10:41 a.m., Resident 14 stated being very concerned about staffing. Resident 14 stated the facility did not have enough staff, and for that reason, she did not get enough help. Resident 14 stated she was left in her wet or soiled disposable brief for more than 2 hours, and was not repositioned often either, it took more than 2 hours for her to get repositioned in bed. Resident 14 stated she had developed urinary tract infections at the facility, and believed they were related to the lack of incontinence care provided to her.</p> <p>(continued on next page)</p>		



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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on [DATE] at 10:17 a.m., she stated night shift staff passed out the water pitchers to the residents, but it was the responsibility of the Certified Nursing Assistants to ensure their assigned residents had water accessible to them.</p> <p>4. During an interview on [DATE] at 10:35 a.m., the Director of Staff Development (DSD) stated if a resident refused a shower, the CNAs (Certified Nursing Assistant) should ask the resident at least three times at various times of the day if the resident was ready for their shower. If the resident still refused their shower, the CNA should get the resident's nurse so the nurse could intervene. The DSD stated sometimes family was called to help persuaded the resident to take a shower. The DSD stated Resident 20 will let a CNA give a shower if she trusts the CNA and she was not in pain.</p> <p>During an interview on [DATE] at 1:20 p.m., the Director of Nursing (DON) reiterated, the CNAs document the showers they gave by completing a shower sheet titled, Shower Body Check Program. The DON gave the shower audits she had for ,d+[DATE] through [DATE], which tracked the shower sheets she received. The DON stated If there was an empty box on the audit sheet, the DON did not know if she received the resident's shower sheet or not.</p> <p>A review of Shower Body Check Program shower sheets located in the shower binder for Saturday, [DATE], indicated there were only 12 shower sheets filled out. A review of the facility's Shower Schedule for Saturday and the Census, dated [DATE], indicated 24 residents should have received a shower, but there were only 12 shower sheets complete and out of the 12 shower sheets completed, six residents refused their scheduled shower. On Saturday, [DATE], the CNAs on the AM shift, PM shift and Night shift gave a total of six showers.</p> <p>A review of Resident 12's Admission Record indicated Resident 12 was admitted on [DATE], with a diagnosis that included paranoid schizophrenia (feeds into delusions (believes something that isn't true no matter how much evidence you give to the contrary), and hallucinations (involve the senses: seeing, feeling, or hearing something that isn't there), it's common for them to feel afraid and unable to trust others), chronic pain, borderline personality disorder (a mental illness that severely impacts a person's ability to manage their emotions), altered mental status (acute confessional state), amongst others.</p> <p>A review of Resident 12's Annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated [DATE], indicated Resident 12 was severely cognitively impaired (causes serious issues with memory and our ability to reason, make decisions or even care for ourselves). Resident 12 was dependent (helper does all of the effort) on his shower.</p> <p>During an observation on [DATE] at 10:47 a.m. Resident 12 was dressed but unkempt, and his hair looked greasy.</p> <p>During an observation on [DATE] at 01:01 p.m., Resident 12 looked unkempt with nasal hairs and ungroomed. Resident 12's facial skin looked very dry with skin flacks all over his face.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Shower Body Check Program shower sheets from [DATE] to [DATE], indicated Resident 12 had two shower refusals in two weeks. There was no documentation on the shower sheets of Resident 12 being asked at least three times at various times of the day if he would like his scheduled shower. There was no other documentation regarding Resident 12's other two scheduled showers. Two shower refusals and no other documentation indicated Resident 12 had zero showers in a two-week period. A review of the facility Shower Schedule, indicated Resident 12 was to have been given a scheduled shower by the Night shift every Wednesday and Saturday.</p> <p>A review of Resident 20's Admission Record, indicated Resident 20 was admitted on [DATE], with a diagnosis including altered mental status, delusional disorders, dementia with behavioral disturbances, anxiety, major depression, bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), amongst others.</p> <p>A review of Resident 20's Quarterly MDS, dated [DATE], indicated Resident 20 was severely cognitively impaired. Resident 20 was dependent on staff for her shower.</p> <p>A review of the Shower Body Check Program shower sheets from [DATE] to [DATE], indicated Resident 20 had one bed bath and one shower refusal (asked three times if she would like her scheduled shower), but no other documentation regarding Resident 20's other two scheduled showers. In a two-week period, Resident 20 had one shower. A review of the facility Shower Schedule, indicated Resident 20 was to have been given a scheduled shower by the PM shift every Tuesday and Friday.</p> <p>A review of Resident 29's Administration Record, indicated Resident 29 was admitted [DATE], with a diagnosis of sequelae of cerebral infarction (stroke caused by disruption of blood flow to the brain), convulsions (involuntary contracture of the muscles), feeding difficulties, muscle weakness, blindness right and left eye, dementia (more confused and forgetful), psychotic disturbances (confused thinking, delusions - false beliefs that are not shared by others, hallucinations - hearing, seeing, smelling or tasting something that isn't there, changed behaviors and feelings), anxiety, major depression, and hemiplegia (paralysis of one side of the body), amongst others. Resident 29's Primary language was Spanish.</p> <p>A review of Resident 29's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated [DATE], indicated Resident 29 could not complete a BIMS (Brief Interview of Mental Status), had a memory problem and cognitive skills for daily decision making was severely impaired, one upper extremity and both lower extremities had functional limitation of range of motion, and Resident 29 needed substantial/maximal assistance with taking a shower.</p> <p>A review of the Shower Body Check Program shower sheets from [DATE] to [DATE], for Resident 29, indicated Resident 29 had one shower, [DATE], otherwise there was no documentation to indicate Resident 29 had her other three scheduled showers or Resident 29 refused her showers over the two-week period. Resident 29 was to receive two showers per week for a total of four showers. A review of the facility Shower Schedule, indicated Resident 20 was to have been given a scheduled shower by the AM shift every Tuesday and Friday.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and concurrent record review, on [DATE] at 4:08 p.m., with the ADON (Assisted Director of Nursing) on Friday, [DATE], 31 residents were supposed to be given scheduled showers, but there were only 16 shower sheets in the binder for [DATE]. There were many refusals as well. The ADON stated if a shower sheet was not in the shower binder, the shower was not done.</p> <p>Record review of the facility policy titled, Bowel &amp; Bladder Training/Toileting Program, dated [DATE] indicated, The purpose of the Bowel and Bladder Training/Toileting Program is to ensure that residents who are incontinent of bowel and/or bladder receive appropriate treatment and services to minimize urinary tract infection and to restore as much normal bowel and/or bladder function as possible in order to prevent skin breakdown/irritation, improve resident morale, and restore resident dignity and self respect.</p> <p>Record review of the facility policy titled, Positioning &amp; Body Alignment, dated [DATE] indicated, Each resident who is partially or totally dependent will be positioned in good body alignment .A positioning schedule is determined by a Licensed Nurse and reflected in the Care Plan, as needed.</p> <p>Record review of the facility policy titled, Water Distribution Guidelines, dated [DATE], indicated, Residents will be offered drinking water throughout the day.</p> <p>The facility Policy &amp; Procedure (P/P) titled, ADL Documentation, revised [DATE], indicated: Purpose: To provide consistency in documentation of resident status and care given by nursing staff. Policy: The Facility will ensure documentation of the care provided to the residents for completion of AOL tasks. Procedure: The CNA will explain the procedure to the resident. II. The CNA will provide AOL care and encourage the resident's independence. III. The CNA will document the care provided on the facility's method of documentation, manually or electronic.</p> <p>The facility job description titled, Certified Nursing Assistance, undated, indicated: . General Duties and Responsibilities: General: Perform all duties as assigned and in accordance with facility's established policies and procedures, nursing care procedures and safety rules and regulations. Bathe residents as assigned and in accordance with established facility procedures (encourage showers and other self-help measures/activities) .</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on observation, interview and record review, the facility failed to ensure proper foot and toenail care was provided for one of 23 sampled residents (Resident 6) when Resident 6's toenails had grown long and thick, Resident 6 was complaining her feet hurt when she wore her shoes and Resident 6 needed a Podiatrist to cut her toenails because they had become too thick for the nurse to cut. In addition, Resident 6's feet looked severely dry and cracked preventing Resident 6 from maintaining the highest practical level of functioning and was at increased risk for foot complications.</p> <p>Findings:</p> <p>A review of Resident 6's Admission Record, indicated Resident 6 was admitted on [DATE], with a diagnosis including a stroke, difficulty walking, muscle weakness, need for assistance with personal care, schizoaffective disorder (a mental disorder), osteoarthritis (degenerative joint disease) amongst others.</p> <p>A review of Resident 6's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 3/13/24, indicated Resident 6 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition.</p> <p>During a concurrent observation and interview on 6/10/24 at 10:34 a.m., Resident 6 stated she needed her toenails cut, which were really long. Resident 6 stated she has not had her toenails cut for months.</p> <p>During an observation and interview on 6/11/24 at 9:37 a.m., Resident 6 stated her toenails were so long her shoes were hurting her. When Resident 6 took off her clogs, Resident 6 had no socks on and her feet looked dry/unkept. Resident 6 allowed pictures of her feet to be taken. Resident 6's feet/toenails were unkempt, with the big toenails were approximately one-half inch long, and all other toenails were long, and needed to be trimmed. Resident 6's feet looked severely cracked and dry, and needed to be moisturized.</p> <p>During an interview on 6/12/24 at 12:10 p.m., Licensed Staff A was shown pictures of Resident 6's feet/toenails. Licensed Staff A stated it must be very uncomfortable for Resident 6 to wear socks and/or shoes because her toenails were so long. Licensed Staff A stated Resident 6's CNA (Certified Nursing Assistant) should have noticed Resident 6's feet during her shower or bed bath and told Resident 6's nurse, who should have assessed Resident 6's feet. Licensed Staff A stated an appointment should have been made for Resident 6 with the podiatrist. Licensed Staff A stated she would feel uncomfortable cutting Resident 6's toenails because they were so thick. Licensed Staff A stated it would be best for a podiatrist to cut Resident 6's toenails. Licensed Staff A stated she would have notified the social worker through (name) (the electronic medical record system), about Resident 6 needing an appointment with a podiatrist.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 11:51 a.m., Licensed Staff P stated Resident 6's toenails looked horrible. Licensed Staff P stated the Certified Nursing Assistant (CNA) assisting Resident 6 with her shower/care and/or Resident 6's nurse should have noticed Resident 6's long toenails and unkempt feet. Licensed Staff P stated she let the social worker know Resident 6 needed to be seen by a podiatrist. Licensed Staff P stated Resident 6's toenails had not been cut for months and were very thick, which required a podiatrist to cut them.</p> <p>During an interview on 6/13/24 at 11:57 a.m., the DON (Director of Nursing) stated the night shift nurses/CNAs would do the resident feet checks. The DON stated the nurses could cut toenails but not CNAs.</p> <p>During an interview on 6/14/24 at 10:15 a.m., the Administrator stated only a RN (Registered Nurse) or physician could cut a resident, who was diabetic, toenails. The Administrator stated CNAs could not cut a resident's toenails at all. The Administrator stated the facility had retained a podiatrist to come to the facility.</p> <p>The Facility Policy/Procedure (P/P) titled, Grooming, revised 1/1/2021, indicated: . F. Nail Care: . ii. Many residents find soaking to be soothing but the main advantage of soaking is the softening and loosening of dirt particles lodged under the nails. iii. A nailbrush can be used to gently remove any remaining dirty particles under the nails. v. Soaking is also recommended for toenails. vi. Instruct the resident to place their feet in a soapy pan of warm water for 5 minutes. vii. Again a nailbrush can be used to gently remove any remaining dirty particles under the nails. viii. Residents who have medical conditions such as diabetes may only have their toenails clipped by a Licensed Nurse .</p> <p>The P/P titled, Foot-Care Of, revised 1/1/2021, indicated: Purpose: To provide hygienic care of the feet, to prevent skin breakdown or infections and to promote comfort. Policy: Foot care is provided to residents as a component of a resident's hygienic program. Procedure: . IV. Fill basin half full of warm soapy water. V. Soak feet. VI. Rinse soapy solution off of the feet with clear water. VII. Dry feet thoroughly, especially between toes. VIII. This procedure may be used daily, when no open lesions are present. IX. Trim nails as needed . XI. Leave resident dry and comfortable. XII. Report any unusual observations to the charge nurse for follow up. XIII. Document procedure in the resident's medical record.</p> <p>The facility job description titled, Charge Nurse, undated, indicated: . General Duties and Responsibilities: Clinical: . o Chart licensed nurses' notes in an informative and d3scriptive manner that reflects the care provided as well as the resident's response to the care . Supervision: . oAssure that nursing personnel follow established nursing procedures . o Assure that nursing personnel are providing adequate nursing care in accordance with established nursing service procedures .</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39621</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 24 sampled residents (Resident 28 and Resident 15) and one discharged resident (Resident 233) who were at risk for falls and had a history of falls, were provided with supervision by direct care staff, and had effective revisions and implementation of their nursing care plans to prevent further falls to keep them safe. Facility policies on safety and management of falls were not followed. As a result, Resident 28, Resident 15 &amp; Resident 233 suffered falls with major injuries at the facility. This may have contributed to Resident 233's death, and Resident 28's dramatic decline, as she is now expected to pass away within 6 months. In addition, 2 of 24 sampled residents suffered falls without major injuries (Resident 227 and Resident 51), due to lack of supervision, creation, revision, and implementation care plans to prevent falls. This had the potential to result in injuries with major injuries, including death to the residents involved.</p> <p>Findings:</p> <p>Record review indicated Resident 28 was admitted to the facility on [DATE] with medical diagnoses including History of Falling (History of having suffered falls, which may indicate increased risk for future falls), Difficulty in Walking, and Muscle Weakness, according to the facility Face Sheet (Facility Demographic).</p> <p>Record review of Resident 28's MDS (Minimum Data Set-An assessment tool) area GG (Section of the MDS that evaluates the amount of assistance a patient needs) dated 4/29/24 indicated she required supervision or touching assistance from staff to transfer to the toilet, transfer to the chair from bed, and walking 10 feet.</p> <p>Record review of a General Acute Care Hospital (GACH) physician progress notes dated 7/08/22 at 5:05 p. m. indicated Resident 28 underwent surgery to repair a left femoral (thigh bone) neck (Upper section of the bone below the head) fracture, which occurred as a result of a fall at the facility. This note indicated, [Resident 28] is a [AGE] year old female . who resides at [Name of Facility], who usually ambulates (Ability to walk) with a walker complaining of left hip pain after ground level fall yesterday. She presented to the ER (emergency room ) today where x-rays demonstrated a impacted left femoral neck fracture. Orthopedics was consulted and she was admitted to the hospitalist service in anticipation of surgical treatment.</p> <p>During an interview with the Medical Records Director on 6/18/24 at 1:40 p.m., she was asked to provide the following documents for every fall Resident 28 has sustained at the facility after January 1st, 2024 (Resident 28 had a long history of falls, therefore, a decision was made to concentrate on the falls suffered this year for the succinctness of this investigation):</p> <p>Fall Risk Evaluation</p> <p>Post-Fall Assessment</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Neurological assessments (A healthcare provider's evaluation of a person's nervous system after a fall to help determine the extent of damage from head trauma and understand its effects) if applicable</p> <p>During an interview with the Director of Nursing (DON) on 6/18/24 at 4:46 p.m., she provided some of the documents requested above for every fall for Resident 28, but not all the documents. The DON stated the ones not provided were not found.</p> <p>1st Fall:</p> <p>Record review of Resident 28's progress note dated 1/18/24 at 12:45 a.m., indicated, Responded to resident's room after a CNA (Certified Nursing Assistant) stated that the resident was observed on the floor. Resident was sitting on her bottom on the floor at the foot of her bed.</p> <p>Record review of the Fall Risk Evaluation dated 1/18/24 at 2:31 p.m., indicated Resident 28's fall risk score after the fall on 1/18/24 was 21, which indicated she was at high risk for falls.</p> <p>Record review of a Post-Fall assessment dated [DATE] (No time documented) indicated that as a result of this fall, Resident 28 suffered a laceration to the back of the head and the right elbow, with bleeding.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among these documents was the neurological assessment documentation after this fall on 1/18/24.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 1/18/24 with the Director of Staff Development (DSD) on 6/20/24 at 5:10 p.m., she stated that after the fall on 1/18/24, a care plan for falls had been developed with the following interventions, 72 hour Neuro (Neurological assessments) started (The DON could not find neurological checks for this fall, above) .[GACH] evaluation offered and refused .Wound care provided. The DSD confirmed there were no interventions were present in the care plan for increased supervision of Resident 28 to prevent further falls.</p> <p>2nd Fall</p> <p>Record review of a nursing progress note dated 2/12/24 at 12:44 p.m., indicated, Resident was observed, sitting on the ground with her arm and elbow stuck in the bed rail of the bed. The resident stated she just slipped trying to get up causing her arm to get stuck in the bed rail. An abrasion is present on her right elbow.</p> <p>Record review of the Fall Risk Evaluation dated 2/12/24 at 1:22 p.m., indicated Resident 28's fall risk score after the fall on 2/12/24 was 29, which indicated she was at high risk for falls.</p> <p>Record review indicated a Post-Fall Assessment was completed after the fall on 2/12/24.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among these documents was the neurological assessment documentation after this fall on 2/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review of Resident 28's care plans for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/12/24. The DSD confirmed there were no new interventions were added, included increased supervision.</p> <p>3rd Fall</p> <p>Record review of a nursing progress note dated 2/16/24 at 3:05 p.m., stated, resident was observed on the floor in her bathroom, when asked what happened the resident stated that she slipped in water or something and landed on her knee.</p> <p>Record review of a Fall Risk Evaluation dated 2/16/24 at 3:08 p.m., indicated Resident 28's score was 13, which indicated her she was at moderate risk for falling, although she had just fallen twice for the month of February 2024.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Post-Fall Assessment or neurological assessment documentation after this fall on 2/16/24.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/16/24. The DSD confirmed there were no new interventions were added, included increased supervision.</p> <p>4th Fall</p> <p>Record review of a facility report titled, #2214 Fall, dated 2/24/24 (No time documented) indicated, Resident was observed sitting on her bottom at bed side. Her bed was in the lowest position and she appeared to slid off the bed onto the floor when trying to get up.</p> <p>Record review of a Fall Risk Evaluation dated 2/24/24 at 7:45 a.m., indicated Resident 28's score was 20, which indicated she was at high risk for falls.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 2/16/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>5th Fall</p> <p>Record review of a progress note dated 3/17/24 at 3:15 a.m., stated, Resident [Resident 28] was observed sitting on her bottom on the floor by the side of the bed. Resident stated that she slid right of the bed.</p> <p>Record review of a Fall Risk Evaluation dated 3/17/24 at 7:06 a.m., indicated Resident 28 received a score of 20, which indicated she was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a Post-Fall assessment dated [DATE] indicated the resident sustained a 2 cm (Centimeter) right elbow laceration as a result of this fall.</p> <p>Record review of a neurological flowsheet dated 3/17/24 indicated neurological checks were initiated for this fall on 3/17/24 and completed on 3/20/24.</p> <p>During a concurrent interview and record review of Resident 28's care plans with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 3/17/24. The DSD stated the care plan for falls did get revised on 4/02/24 (16 days after the fall on 3/17/24) with the following intervention, Hourly Rounding.</p> <p>6th Fall</p> <p>Record review of a progress note dated 4/04/24 at 3:39 p.m., indicated, called to resident room STAT (Immediately), upon getting to room resident noted on the floor in the sitting position .resident stated she was standing eating her Peanut Butter and jelly sandwich, then fell to the ground hitting her Right elbow.</p> <p>Record review of a Fall Risk Evaluation dated 4/15/24 at 2:33 p.m. (More than 10 days after the fall on 4/04/24) indicated Resident 28's fall risk score was 14, which indicated she was at moderate risk for falls, despite having just fallen on 4/04/24 according to the progress note dated 4/04/24 at 3:39 p.m. (above)</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Post-Fall Assessment or neurological assessment documentation after this fall on 4/04/24.</p> <p>During a concurrent interview and record review with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 4/04/24. The DSD confirmed no new interventions were added, including increased supervision.</p> <p>7th Fall</p> <p>Record review of a progress note dated 5/10/24 at 9:39 p.m., indicated, Resident had a fall this shift around 9pm. Observed on her R (Right) side on the [NAME] hallway with only one shoe on. Voiced that she lost her balance.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Fall Risk Evaluation or neurological assessment documentation after this fall on 5/10/24.</p> <p>A Post-Fall assessment was completed on 5/10/24 and indicated there were no obvious signs of injury.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 4/04/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>8th Fall</p> <p>Record review of Resident 28's progress note dated 5/13/24 at 9:53 p.m., indicated, resident had an unwitnessed fall in her room. Resident was observed on the ground outside her bathroom.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Fall Risk Evaluation or neurological assessment documentation after this fall on 5/13/24.</p> <p>Record review of a Post-Fall Assessment completed on 5/13/24 indicated there were no obvious signs of injury.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/13/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>9th Fall</p> <p>Record review of a progress note dated 5/19/24 at 5:48 p.m., indicated, This writer went in to check on resident and observed the resident with her RT (Right) knee on the ground holding on to her wheeled walker trying to come to a standing position. When resident was asked what happened she stated that she had fallen like that multiple time (The documentation did not indicate what time this occurred) today.</p> <p>Record review of a Fall Risk Evaluation dated 5/19/24 at 7:13 p.m., indicated Resident 28's score was 25, which indicated she was at high risk for falls.</p> <p>Record review of a Post-Fall assessment dated [DATE] indicated the resident had pain of 8/10, All over, although no obvious signs of injury were present.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the neurological assessment documentation after this fall on 5/19/24.</p> <p>During a concurrent interview and record review of Resident 28's care plans for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/19/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>10th Fall</p> <p>Record review of a progress note dated 5/26/24 at 1:25 p.m., indicated, Resident [Resident 28] had a fall this afternoon. Found on the floor lying in front of her bathroom. Stated that she lost her balance.</p> <p>Record review of a Fall Risk Evaluation dated 5/26/24 at 1:29 p.m. indicated her score was 12, which indicated she was at moderate risk for falls, although she had fallen 10 times in five months.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Post-Fall Assessment after the fall on 5/26/24.</p> <p>Record review of neurological assessments initiated on 5/26/24 after the fall, indicated several boxes were not documented on and left blank; therefore, the neurological assessment was incomplete.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/26/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>11th Fall</p> <p>Record review of a progress note dated 5/31/24 at 8:07 a.m. indicated, Responded to a nurse stat. Resident was laying on her stomach on the floor with her arms out in front of her and her wheeled walker out in front of her. Resident stated that she fell to her knees and then the walker kept going without her.</p> <p>Record review of the Fall Risk Evaluation dated 5/30/24 at 4:25 p.m., indicated Resident 28's score was 27, which indicated she was at high risk for falls.</p> <p>During an interview on 6/18/24 at 4:46 p.m., the DON stated being unable to find several documents requested, among them was the Post-Fall Assessment after the fall on 5/31/24.</p> <p>Record review of a progress note dated 5/31/24 at 4:35 a.m. indicated Resident 28 refused neurological assessments after the fall on 5/31/24.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated there was no evidence the care plan for falls for Resident 28 had been revised or updated after the fall on 5/26/24. The DSD confirmed there were no new interventions added, including increased supervision.</p> <p>12th Fall, with Major Injury</p> <p>Record review of a progress note dated 6/12/24 at 4:25 a.m., indicated, 0320 (3:20 a.m.) CNA found resident sitting on floor, stat called resident stated she slipped out her wheelchair onto the floor .resident c/o (Complained of) right hip pain 8/10 (Pain level of 8 out of 10, where 0 signifies no pain, and 10 is the worst pain experienced in a person's lifetime. A level of 8 out of 10 indicates severe pain) has history of right hip FX (Fracture), sent resident out to [GACH] for assessment.</p> <p>Record review of a Fall Risk Evaluation dated 6/12/24 at 8:35 a.m., indicated Resident 28 score was 22, which indicated she was at high risk for falls.</p> <p>Record review of neurological flow sheets indicated no neurological assessments were documented, probably because Resident 28 was transferred to a GACH right away.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a GACH after visit summary dated 6/17/24 (No time documented) indicated Resident 28 was diagnosed with a fracture of the right femoral neck on 6/12/24 (After the fall on 6/12/24 at 3:20 a.m.) This GACH after visit summary indicated Resident 28 underwent surgery to repair the fracture to the right hip.</p> <p>Record review of a Post-Fall assessment dated [DATE] indicated resident 28 developed pain on her right hip as a result of the fall.</p> <p>During a concurrent interview and record review of Resident 28's care plan for falls initiated on 8/22/22 with the DSD on 6/20/24 at 5:10 p.m., she stated the care plan for falls was updated on 6/16/24 with the following interventions, continue to offer safety equipment and devices in the event resident changes her preferences . encourage resident to make safe choices to minimize risk for injury .patient education. The DSD confirmed there was no mention of increased supervision. The DSD reviewed all of Resident 28's active care plans and could not find a care plan for care of the right hip fracture.</p> <p>Record review of all care conferences conducted for Resident 28 since January 1st to the present (6/21/24) indicated only one care conference was conducted for Resident 28 in 2024, and this was on 1/15/24, despite all her falls. This care conference did not include any documentation on falls.</p> <p>During an interview with Unlicensed Staff H (Resident 28's assigned nursing assistant) on 6/19/24 at 5:35 p. m., she stated she checked on Resident 28 every hour. Unlicensed Staff H stated Resident 28 thought she could do more than she was capable of doing, and sometimes she would forget things. Unlicensed Staff H also stated Resident 28 needed supervision for toileting.</p> <p>During an interview on 6/19/24 at 5:45 p.m., Licensed Staff I, (Resident 28's assigned nurse) stated that prior to Resident 28's last fall with fracture (Which occurred on 6/12/24) Resident 28 was very wobbly because she was recovering from a urinary tract infection. Licensed Staff I stated she did not check on the resident at regular time intervals.</p> <p>During a concurrent observation and interview with Resident 28 on 6/20/24 at 10:05 a.m., she stated she could not remember any falls and did not know anything about fractures. Resident 28 did state she felt very uncomfortable, and her pain level was a 10/10. Resident 28 stated the pain came from her pelvic area. Resident 28 was observed with fresh sutures from the hip surgery on the right hip. Resident 28 was observed in bed at the time of the interview.</p> <p>During an interview with Anonymous Witness J on 6/14/24 at 4:15 p.m., he/she stated Resident 28 had fallen frequently because administration would not institute a one to one (One staff assigned to only one resident for increased care or supervision) to work with her, and in addition, Resident 28 did not have tab alarms (Alarms that detect motion and notify staff that a resident is on the move). Anonymous Witness YY stated certified nursing assistants were assigned 16 to 20 residents per shift, which did not provide them enough time to perform all activities of daily living (Activities for personal care, such as showering, toileting, etc.) and supervise residents at risk for falls. Anonymous Witness J also stated that even if the facility had enough certified nursing assistants to work as a one to one with a resident at risk for falls, the Administrator would send them home, and only once, in his/her employment at the facility, had he/she observed a one to one, and it was because the resident was extremely aggressive.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a progress note dated 6/13/24 at 11:16 a.m., indicated, Resident RP (Patient representative) mailed a letter for IDT (Interdisciplinary team) conference to discuss falls and 6 month or less to live prognosis.</p> <p>Record review of a progress note dated 6/19/24 at 1:01 p.m., indicated, resident [Resident 28] appears to be declining. The resident needed her medication put in applesauce and she never has before. The residents teeth kept shaking uncontrollably. The resident has been resting for most of the shift.</p> <p>Resident 15</p> <p>Record review indicated Resident 15 was admitted to the facility on [DATE] with medical diagnoses including Muscle Weakness, and Difficulty in Walking, according to the facility Face Sheet.</p> <p>Record review of an untitled and undated facility report for falls, indicated Resident 15 had suffered 18 falls at the facility since her admission, with the first one occurring on 10/11/20 at 1:30 p.m., (6 days after her admission), and the last one on 4/08/24 at 7:45 p.m. The investigation below focuses on the last three falls suffered at the facility.</p> <p>Record review of a care plan for falls initiated on 7/02/22 indicated, Anticipate my needs Assist with transfers as needed .Hourly Rounding checks for safety.</p> <p>First Fall:</p> <p>Record review of a progress note dated 8/24/23 at 1:51 p.m., indicated, Patients roommate came out of the bathroom and observed her roommate lying on the floor and came and got a nurse. Observed resident sitting on floor next to bed. No visible injuries noted.</p> <p>Record review of a Fall Risk Evaluation dated 8/24/23 at 2:56 p.m., indicated Resident 15 was at low risk for falls (although she had just fallen) because no questions in this form were answered, in fact, nothing was filled out. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>Record review of the care plan for falls for Resident 15 indicated it was not revised or updated after the fall on 8/24/23, and no new interventions were added, including increased supervision. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>2nd Fall</p> <p>Record review of a progress note dated 9/13/23 at 7:46 a.m., indicated, S/P (Status post [After]) fall, day #1. There were no other progress notes or documentation indicating how the fall occurred, or the circumstances surrounding the fall.</p> <p>Record review of a Fall Risk Evaluation dated 9/12/23 at 1:38 p.m., indicated Resident 15 received a score of 16, which indicated she was at high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the care plan for falls for Resident 15 indicated it was not revised or updated after the fall on 9/13/23, and no new interventions were added, including increased supervision. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>3rd Fall</p> <p>Record review of a facility report titled, 2263 (Unknown what this number means) Fall, dated 4/08/24 at 7:45 p.m., indicated, [Resident 15] Observed on floor in resident's bathroom. Lying on left side, head up against the wall, feet at the toilet area. Floor was wet .Resident stated that her right ankle hurt.</p> <p>Record review of a progress note dated 4/09/24 at 1:26 a.m., indicated, Resident arrived back at the facility around 12:46 am from [GACH] via stretcher .Dx (Diagnosis) of closed ankle fracture (Broken bone that does not protrude through the skin at the level of the ankle) .Rt (Right) ankle with splint and compression bandage intact.</p> <p>Record review of a Fall Risk Evaluation dated 4/09/24 at 12:02 a.m., indicated Resident 15's score was 5, which indicated she was at low risk for falls (although she had just fallen and fractured her right ankle). During an interview with the DSD on 6/20/24 at 10:30 a.m., she confirmed this Fall Risk Evaluation had been answered inaccurately as it indicated Resident 15 had no history of falls.</p> <p>Record review of neurological assessments initiated for Resident 15 on 4/08/24 (after the fall) were initiated but not completed as several boxes were left without documentation and were blank. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>During a concurrent interview and record review of Resident 15's care plans for falls with the DSD on 6/20/24 at 10:30 a.m., the DSD confirmed no new interventions were added after the fall on 4/08/24 (including increased supervision). The DSD confirmed she could not find a care plan for care of the fracture.</p> <p>Resident 233</p> <p>Record review indicated Resident 233 was admitted to the facility on [DATE] with medical diagnoses including Dementia (Memory loss), Difficulty in Walking, and Muscle Weakness, according to the facility Face Sheet.</p> <p>Record review of Resident 35's MDS dated [DATE] indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 5, which indicated her cognition was severely impaired (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). In this assessment, Resident 233 was asked to repeat the words, sock, blue and bed, after they were spoken by the MDS evaluator and Resident 233 was only able to repeat one word after the first attempt. Resident 233 was unable to remember the word, blue, according to this assessment.</p> <p>1st Fall</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a progress note dated 3/27/24 at 11:45 p.m., indicated, Witnessed fall, by one of the aids. Slow decent to the floor after tripping over wheelchair when trying to pick up something up off the floor.</p> <p>Record review of a Fall Risk Evaluation dated 3/27/24 at 11:54 p.m., indicated Resident 233 received a score of 2, which indicated she was at low risk for falls, although she had just fallen hours earlier at the facility. A section of this Fall Risk Evaluation titled, Gait Analysis, was left blank by the person filling out the form, therefore, the fall risk score was inaccurate, according to the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>Record review of a care plan initiated on 3/27/24 after the fall, had only one intervention. The intervention indicated, Staff will continue to educate resident about waiting for staff to help pick up items off of floor when they fall. Resident 233 had been unable to recall the word, blue, during the MDS assessment dated [DATE] (above) and her cognition was noted to be severely impaired. There were no interventions to increase Resident 233's supervision added to the care plan. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>2nd Fall with Major Injury</p> <p>Record review of a facility report titled, #2254 (Unknown what this number indicates) Fall, dated 3/29/24 at 10:19 p.m., indicated, Resident was observed lying beside her bed on her bottom .Resident Unable to Give Description.</p> <p>Record review of a Fall Risk Evaluation dated 3/29/24 at 11:24 p.m., indicated Resident 233 received a score of 10, which indicated she was at moderate risk for falls, despite having just fallen twice in less than one week according to the facility report titled #2254 Fall, dated 3/29/24 at 10:19 p.m., and progress note dated 3/27/24 at 11:45 p.m.</p> <p>Record review indicated neurological assessments were initiated after the fall on 3/29/24 but portions of the form were not completed. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>Record review of a progress note dated 4/02/2024 at 11:41 a.m., indicated that as a result of the fall on 3/29/24, Resident suffered a left femur (Thigh bone) fracture.</p> <p>Record review of a progress note dated 4/14/22 at 8:13 a.m., indicated, Resident has passed away on 4/14/24. Her death occurred 16 days after the fall with fracture, suffered at the facility.</p> <p>Record review of a care plan initiated on 3/29/24 after the fall, had only one new intervention. The intervention indicated, Hourly Rounding. There were no care plans created to care for the fracture. This was confirmed by the DSD during an interview on 6/20/24 at 10:30 a.m.</p> <p>35842</p> <p>Resident 227</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Some	<p>A review of Resident 227's Admission Record, indicated resident 227 was admitted on [DATE], with a diagnosis including cerebral infarction (stroke), difficult walking, dysphagia (difficulty in swallowing), age-related osteoporosis (causes bones to become weak and brittle), tremor (involuntary quivering movement), restless leg syndrome (an overwhelming urge to move your legs), high blood pressure, hemiplegia (paralysis), aphasia (trouble communicating or understanding), osteoarthritis (wear and tear disease on the joints in one's hands, legs, knees, hips, lower back and neck causing pain and stiffness), amongst others.</p> <p>A review of Resident 227's admission Fall Risk Evaluation, dated 5/10/24, indicated Resident 227 was at moderate risk for falls.</p> <p>Fall 1</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/11/24 at 1:30 a.m., indicated Resident 227 had an unwitnessed fall in the bathroom, which caused a skin tear to Resident 227's right arm below her elbow. A review of Resident 227's care plan indicated no Fall care plan was implemented after Resident 227's fall on 5/11/24.</p> <p>A review of Resident 227's Admission MDS, dated [DATE], indicated Resident 227 had a BIM score of 3, which meant Resident 227's cognitive skills for decision making was severely impaired. Section J - Health Condition indicated Resident 227 had a fall in the last month prior to admission/entry or reentry into the facility and Resident 227 had a fall in the last two-six months prior to admission/entry or reentry into the facility. Section V- Care Area Assessment (CAA) Summary of Resident 227's MDS, indicated the Care Area for Falls triggered.</p> <p>Fall 2</p> <p>A review of Resident 227's Change of Condition Summary dated 5/26/24, indicated Resident 227 had an unwitnessed fall at 6 a.m. A Certified Nursing Assistant (CNA) found Resident 227 on the floor in the bathroom and alerted Resident 227's nurse. An assessment was performed. Resident 227 was complaining of pain to her right arm and Resident 227 had a small bump assessed at the back of her head. Resident 227 did not want to go to hospital. A review of Resident 227's care plan indicated no Fall care plan was implemented after Resident 227's second fall.</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/26/24 at 10:33 p.m., indicated Resident 227 went to the hospital to be assessed for further evaluation after falling that morning at 6 a.m.</p> <p>A review of Resident 227's Change of Condition Summary, dated 5/27/24 at 1:53 a.m., indicated Resident 227 had gone to the hospital to have her right shoulder checked. Resident 227 returned from the hospital via a non-emergency ambulance at 12:25 a.m. with a diagnosis Contusion of Right Shoulder. The Administrator, DON, and Resident 227's physician was notified about the diagnosis from the 5/26/24 post fall.</p> <p>Fall 3</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 227's Change of Condition Summary, dated 5/28/24 at 6:39 a.m., indicated the nurse was notified by a staff employee Resident 227 was on the floor next to her bed. The nurse found Resident 227 in a semi sitting position, an assessment was performed, a minor skin tear noted at Resident 227's left forearm, and no other injuries noted. Resident 227 had denied any pain. The facility unwitnessed fall protocol was implemented, which included neuro checks for 72 hours.</p> <p>A review of Resident's 227's care plan, indicated Resident 227 had an Fall care plan, initiated 5/28/24 for the actual fall. Focus: (Specified: No Injury, minor injury, serious injury), poor balance, and unsteady gait. Goal: Resident 227 will resume usual activities without further incident through the review date. Interventions: [NAME] [TRUNCATED]</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on observation, interview and record review, the facility failed to provide the necessary care and services related to significant and/or severe weight loss or gain for five out of 23 sampled residents (Resident 12, 20, 25, 29 and 227) to ensure the residents maintained an acceptable nutritional status because:</p> <ol style="list-style-type: none"> <li>1. The RD (Registered Dietician) was making quarterly visits (once every three months), which led to minimal in person resident assessments,</li> <li>2. The RD failed to fully tailor the resident's nutritional interventions to the resident's needs and monitor the continued relevance of those interventions such as residents' functional factors and lack of adequate assistance or supervision during meals,</li> <li>3. The Dietary Manager who has no professional scope of practice was completing the resident's Annual and Quarterly Dietary Progress Notes which included recommendations and initiating resident's Nutritional Risk care plan,</li> <li>4. The Dietary Manager incorrectly coded residents who had either lost or gained a significant amount of weight in their MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) under Section K (Swallowing/Nutritional Status). The coding for Residents 20 indicated, a physician-prescribed weight gain regimen when the physician had not written an order. The coding for Resident 12 indicated, not on physician-prescribed weight-loss regimen when there was a physician's order for a weight loss regimen,</li> <li>5. The weekly Weight Variance Meeting document titled, Skin and Weight Review, the Clinical section, which was supposed to filled out by the RN (Registered Nurse) on the committee, was not consistently completed,</li> <li>6. Residents' meal and fluid intake was not being monitored closely, and</li> <li>7. Residents who needed supervision with their meals and fluid intake were not consistently supervised.</li> </ol> <p>These failures had the potential to place Resident 12, Resident 20, Resident 25, Resident 29, and Resident 227 at risk for altered nutritional status and/or dehydration (occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and other fluids to carry out its normal functions) that could lead to further health complications, hospitalization and even death.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Practice Paper published by the American Dietetic Association, dated 2010, indicated In older adults, a 5% or more unplanned weight loss in 30 days often results in protein-energy undernutrition as critical lean body mass is lost.that may trigger sarcopenia [a condition characterized by loss of skeletal muscle mass and function] and functional decline [a loss of independence in self-care capabilities and deterioration in mobility and in activities of daily living]. (American Dietetic Association: Individualized Nutrition Approaches for Older Adults in Health Care Communities, October 2010 Journal of the American Dietetic Association).</p> <p>Involuntary weight loss can lead to muscle wasting depression and an increased rate of disease complications. Various studies demonstrated a strong correlation between weight loss and morbidity and mortality. (February 15, 2002/Volume 65, Number 4 www.aafp.org/afp American Family Physician)</p> <p>A publication titled, Nutrition Care of the Older Adult from the Academy of Nutrition and Dietetics, dated 2016, indicated the goal of Medical Nutrition Therapy is to maintain or restore the individual's usual body weight. During a review of the Academy of Nutrition and Dietetics Evidence Analysis Library regarding Unintended Weight Loss for Older Adults Evidence-Based Nutrition Practice Guidelines (2007-2009), indicated: the Registered Dietitian (RD) should monitor and evaluate weekly body weights of older adults with unintended weight loss, until body weight has stabilized, to determine effectiveness of medical nutrition therapy (MNT).</p> <p>The State Operations Manual (SOM) provides these parameters for significant weight loss:</p> <p>Interval Significant Loss Severe Loss</p> <p>1 month 5% Greater than 5%</p> <p>3 months 7.5% Greater than 7.5%</p> <p>6 months 10% Greater than 10%</p> <p>Gradual unintended weight loss over time is known as insidious weight loss. This can be where an older adult loses only 1-2 pounds per month, but for a continued period. When addressing unintentional weight loss, one needs to figure out why, if possible, the root cause of unintended weight loss (Geriatric Dietitian, 3/31/22).</p> <p>A Nutrition-focused physical findings assessment, often referred to as clinical assessment, are findings from evaluation of body systems, muscle and subcutaneous fat wasting, oral health, hair, skin and nails, signs of edema, suck/swallow/breath ability, appetite and affect. The intent of this assessment is to intervene in findings that are relevant to patient care. (Journal of the Academy of Nutrition and Dietetics, 2013).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>The National Library of Medicine defines the care planning process as a systematic process to client-centered care with 5 sequential steps. These are assessment, diagnosis, planning, implementation, and evaluation. The assessment is the first step and involves critical thinking skills and data collection; subjective and objective. Subjective data involves verbal statements from the patient or caregiver. Objective data is measurable, tangible data such as vital signs, intake and output, and height and weight. Critical thinking skills are essential to assessment. Patient assessment is reserved for those professionals who have a legal scope of practice. The Certified Dietary Manager does not have a scope of practice in California Law.</p> <p>CMS (Centers for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 indicates under Section K: Swallowing/Nutritional Status states The assessor should collaborate with the dietitian .to ensure that items in the section have been assessed and calculated accurately .</p> <p>1. A review of Resident 29's Administration Record, indicated Resident 29 was admitted [DATE], with a diagnosis of sequelae of cerebral infarction (stroke caused by disruption of blood flow to the brain), convulsions (involuntary contracture of the muscles), feeding difficulties, muscle weakness, blindness right and left eye, dementia (more confused and forgetful), psychotic disturbances (confused thinking, delusions - false beliefs that are not shared by others, hallucinations - hearing, seeing, smelling or tasting something that isn't there, changed behaviors and feelings), anxiety, major depression, and hemiplegia (paralysis of one side of the body), amongst others. Resident 29's Primary language was Spanish.</p> <p>A review of Resident 29's Quarterly MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/12/24, indicated Resident 29 could not complete a BIM (Brief Interview of Mental Status), had a memory problem and cognitive skills for daily decision making was severely impaired, one upper extremity and both lower extremities had functional limitation of range of motion, Resident 29 needed supervision or touching assistance with eating (The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or once the meal is placed before the resident), and Section K - Swallowing/Nutritional Status, indicated Resident 29 had weight loss of 5% or more in the past month or loss of 10 % or more in the last six months. and Resident 29 was not on a physician-prescribed weight loss regimen.</p> <p>Weight Review</p> <p>A review of Resident 29's Weights and Vital s Summary, documented from 11/9/23 through 6/3/24, indicated the following:</p> <p>11/9/2023: 141.9 lbs.</p> <p>12/5/2023: 142.5 lbs.</p> <p>1/4/2024: 139.6 lbs.</p> <p>2/6/24: 130 lbs.</p> <p>2/8/24: 127.1 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/12/24 at 12:40 p.m., there were two staff members (Unlicensed Staff C and a nurse) for nine residents in the Total Assisted Dining (TAD) Room. Resident 29 was trying to communicate in Spanish but was being ignored. Unlicensed Staff C and the nurse in the TAD Room did not speak Spanish, so Unlicensed Staff C and the nurse could not understand Resident 29 in order to meet her dining needs. Unlicensed Staff C nor the nurse got someone who could communicate in Spanish with Resident 29. Resident 29 was legally blind. There was no staff member sitting next to Resident 29 to guide her on where her food was on her plate. Unlicensed Staff C and the nurse were both sitting at the other end of the table feeding a resident. Unlicensed Staff C did place a plate guard (helps prevent food from accidentally being pushed off the plate while eating, minimizing spills at mealtime) on Resident 29's plate and handed her a fork. Resident 29 started eating her pasta with her fingers. Resident 29 did not receive staff assistance to guide her with using her fork or where food items were on her plate.</p> <p>During an observation on 6/14/24 at 11:15 a.m., Resident 29 was in bed with her head covered with a blanket. There was a light yogurt with a spoon in it, container indicated worth 100 calories, zero consumed, and a chocolate shake with a straw, container indicated worth 200 calories, 75% consumed. There was no straw in Resident 29's water pitcher, which felt almost empty and no cup to pour water into. Resident 29 was legally blind and her overbed table was at the side of her bed out of reach. Through multiple observations while Resident 29 was in bed from 6/11/24-6/13/24, never observed a nurse or CNA go into Resident 29's room and offer her fluids.</p> <p>A review of Resident 29's Nutritional Data Collection and Assessment, dated 5/8/24 (6 months after the resident began to lose weight) was completed by the RD. Resident 29's estimated needs were listed as 1917 calories, 68 grams of protein and 1373-1585 cc's of fluid (cubic centimeters-a metric unit of measure). The assessment indicated Resident 29 was on a nutritional supplement three times/day, with meals which was initiated on 2/20/24, and was receiving Mirtazapine (an antidepressant which may increase appetite), which was initiated on 2/2/24. The assessment: acknowledged an unplanned weight change, however did not recognize it as a severe weight change and included the need for adaptive equipment (a divided plate and plate guard). The assessment indicated Resident 29 had inadequate intakes. The RD also commented Resident 29 liked coffee. There were no additional recommendations or assessment of the effectiveness of current interventions. There was no plan to develop nutritional implementations that emphasized Resident 29's preference for coffee, such as coffee flavored high calorie beverages. The note also indicated Resident 29 thinks the food is poisoned, refuses everything, however there was no indication the facility attempted to assess the rationale of these comments. The RD indicated a referral to the physician regarding Resident 29's statements, however the facility was unable to validate the referral. There was no additional follow up from the Registered Dietitian despite continued weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 29's At Risk for Nutritional Problems, care plan, the Focus section was created and initiated by the Dietary Manager on 4/3/2019. There was no revision of the nutritional risk care plan by the RD (Registered Dietitian) until 5/9/24 (six months after the start of severe weight loss). Interventions initiated by the Dietary Manager, dated 4/3/19 were as follows: encourage fluids and encourage oral intake. The Dietary Manager continued to initiate interventions dated, 5/23/22 as follows: assist resident with meals as needed, assistive devices as ordered: divided plate/plate guard and describe the location of food on resident's plate/tray, and offer meal alternate if less than 50% of meal eaten, provide between meal feedings and supplement as ordered. There were no additional updates or evaluation of effectiveness of the care plan despite continued weight loss. A RD initiated a note, dated 5/22/23, Continue current diet (mechanically altered diet) and POC (Plan of Care). Resident regaining weight toward initial admission weight. Interventions were not revised by the RD from 11/9/23-6/3/24 when Resident 29 had three-month and six-month severe weight loss. It was noted the RD indicated the resident was regaining weight, despite continued weight loss.</p> <p>A review of Resident 29's Order Summary Report, indicated Resident 29 was on a NAS (No Added Salt) Mechanical Soft with chopped meat texture, thin liquids consistency, fortify (extra nutrients added) cereal at breakfast and milk three times a day and provide a divided plate and plate guard at each meal, start date 9/28/22, Mirtazapine (used to increase appetite and weight gain) 7.5 milligrams (mg) one tablet by mouth at bedtime, started date 2/20/24 and HPN (High Performance Nutrition) shakes three times per day with meals started, 2/20/24.</p> <p>Hydration Review</p> <p>A review of Resident 29's Medication Administration Record (MAR), dated 4/24, 5/24, and 6/24, indicated Resident 29 was given HPN with meals but did not indicate amount consumed.</p> <p>A review of Resident 29's quarterly Dehydration Risk Evaluation-V3. dated 11/18/23, score of 4 and quarterly Dehydration Risk Evaluation-V3. dated 5/8/23, score of 6, indicated Resident 29 was Moderately at Risk for dehydration (A condition that occurs when the body loses too much water and other fluids that it needs to work normally). Resident 29's quarterly Dehydration Risk Evaluation-V3 for 2/2024 was not completed.</p> <p>An interview on 6/14/24 at 10:50 a.m., the Administrator was asked about resident's missing quarterly 2/2024 Dehydration Risk Evaluation. The Administrator stated the dedicated nurse assigned to the task of doing the resident's quarterly Dehydration Risk Evaluations had quit and the DON (Director of Nursing) did not realize it needed to be reassigned so there was a gap.</p> <p>A review of Resident 29's Potential Fluid Deficit care plan, initiated 1/21/19, interventions included: encourage resident to drink fluids, resident was blind and only spoke Spanish, needed assistance with fluid intake in order to meet daily requirements and monitor and document all intake in resident's electronic medical record.</p> <p>A review of Resident 29's Fluid Intake, task in Resident 29's electronic medical record, dated 3/19/24 -6/19/24, did not indicate if Resident 29 consumed her HPN at breakfast, lunch, and dinner time.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 29's Fluid Intake task, indicated Resident 29's fluid intake was not monitored per Resident 29's Potential Fluid Deficit care plan. Resident 29's documented 24-hour fluid intake, for the period of 3/22/24-6/10/24 was 240 ml or less for 40 of 78 days, a daily deficit range of 1133-1345 ml.</p> <p>During an interview on 6/19/24 at 5:18 p.m., the Director of Staff Development (DSD) stated the Fluid Intake task only showed the fluids residents consumed on their meal tray. The DSD stated the CNAs (Certified Nursing Assistants) should be documenting the fluids residents consumed on their meal tray or document refusal.</p> <p>A review of Resident 29's Meal Intake task, dated 3/19/24 -6/19/24, indicated there was no documentation of Resident 29's percentage of breakfast meal intake for 46 of 78 days. No documentation of Resident 29's percentage of lunch intake as for 58 of 78 days. No documentation of Resident 29's percentage of dinner intake for 9 of 78 days. It was also noted Resident 29 refused 27 meals (breakfast, lunch or dinner) in 78 days. There was no indication the facility attempted to determine a reason for the refusals. Similarly, there were 10 lunch and 12 dinner refusals.</p> <p>A review of Resident 29's Meal Intake task, dated 3/19/24 -6/19/24, indicated per refusals for breakfast and lunch on 3/21/24, refusal for breakfast on 3/29/24, and refusal for dinner on 3/25/24, 4/12/24, 4/19/24, 4/27, 5/8/24, 5/23/24, 6/4/23, and 6/10/23, and because of lack of documentation of Resident 29's meal intake for her other meal(s) on those same days, indicated Resident 29 ate zero food for ten days. Per fluid intake documentation during this time period, Resident 29 drank 250 ml (milliliters) or less of fluids on five of those ten days, 3/25/24, 4/12/24, 5/5/24, 6/4/24 and 6/10/25.</p> <p>A review of Resident 29's Meal Intake task, dated 3/19/24 -6/19/24, indicated on the days Resident 29 refused meals and because of lack of documentation for meal intakes, on 3/23/24, 3/24/24, 3/30/24, 3/31/24, 4/1/24-4/3/24, 4/6/23-4/8/24, 4/14/24, 4/23/24, 4/26/24, 4/30/24, 5/5/24-5/7/24, 5/12/24-5/13/24, 5/18/24, 5/20/24-5/22/24, 5/26/24, 5/30/24, 6/1/24-6/3/24, 6/6/24, and 6/18/24, Resident 29 only consumed 0-25% of her meals for the entire day. Per fluid intake documentation, Resident 29 drank 250 ml or less for 13 of 30 meal intakes (4/2/24, 4/6/24-4/7/24, 5/6/24-5/7/24, 5/12/24, 5/18/24, 5/26/24, 5/30/24, 6/1/24-6/2/24, 6/6/24, and 6/8/24) whereby Resident 29 consumed 0-25% of her meals for the entire day, and zero fluid intake for nine of the 30 days, 3/31/24, 4/1/24, 4/14/24, 4/23/24, 4/26/24, 5/5/24, 5/20/24-5/21/24 and 6/3/24.</p> <p>During a concurrent phone interview and record review on 6/14/24 at 8:50 a.m., the RD stated the last time she was at the facility was 4/20/24. The RD stated she came to the facility quarterly. The RD stated since the Dietary Manager was seasoned, she relied on him to identify and implement interventions. The RD stated the Dietary Manager along with the ADON (Assistant Director of Nursing) did the weekly Skin and Weight Reviews or NAR (Nutrition Assessment Review), which was the weekly weight variance. When asked how she would do a Nutrition Focused Physician Exam, the RD stated she would have to be in the facility to do an assessment on the resident. The RD stated she did the resident's Initial Nutritional Assessment based a lot on the information she gathered from the Resident's Nursing Admission Assessment, which was done by the admitting nurse. The RD stated Resident 29 did not eat but preferred coffee per information gathered from the facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent phone interview and record review on 6/14/24 at 8:50 a.m., Resident 29's Nutritional Data Collection and Assessment, dated 5/5/24, indicated a score of 4, which meant Resident 29 was at Moderate Risk for nutritional issues. The RD stated Resident 29 was not having any weight loss issue, no chewing/swallowing issues and ate 50-100% of her meals. It was pointed out to the RD Resident 29 had triggered for severe weight loss. The RD stated Resident 29 did go to the TAD (Total Assistant Dining) and the RD would rely on the RNA (Restorative Nursing Assistant: interacts with the resident and provides skill practice in such activities as eating) to determine the level of assistance Resident 29 needed. The RD stated she knew Resident 29 had an issue about thinking her food was poisoned and acknowledged she had not observed Resident 29 during dining. The RD stated the weekly Weight Variance, included the RD by phone, the ADON and the Dietary Manager, and she referred to the ADON during their weekly Weight Variance meetings to pass on her recommendations to the resident's physician to help improve the resident's weight. The RD relied on the Dietary Manager, the ADON, and the Resident's nurse along with record review to figure out why the resident was losing weight.</p> <p>During a concurrent phone interview and record review on 6/14/24 at 8:50 a.m., a review of the RD onsite facility visits requested titled, Dietician Consultant Monthly Report, which the Dietary Manager hand delivered, indicated there was only one, dated 4/18/24 (Note: RD started 7/2023). During the six-month period of Resident 29's severe weight loss, there was no documentation of a nutritional assessment by a RD. The RD was not able to recall if she saw Resident 29. The RD stated the resident's care plan was generated by nursing and the Dietary Manager updated the resident's care plan. The surveyor indicated to the RD the Dietary Manager has no professional clinical license or professional scope of practice when initiating and/or adding to a resident's care plan. Note: Concurrent review of Resident 29's At Risk for Nutritional Problems, care plan indicated the initial plan was created and initiated by the Dietary Manager on 4/3/2019.</p> <p>A review of Resident 29's Skin and Weight Review, dated 2/10/24, 2/15/24, 2/24/24, 3/8/24, 3/14/24, 4/12/24, 4/19/24, and 5/10/24, noted the Clinical section was signed by the Assistant Director of Nursing (ADON) and the Dietary, section was signed by the Dietary Manager. There was no indication the RD participated in the recommendations to help improve Resident 29's weight. The clinical section indicated Resident 29 had Significant Weight Loss and was to eat in the Restorative Dining (TAD: Total Assisted Dining). The ADON clinical notes indicated Resident 29 needed assistance with cueing and prompting when eating, and Mirtazapine (an anti-depression medication with a potential benefit of appetite stimulation) and health shakes were started. The ADON did not address Resident 29 being legally blind and her primary language being Spanish.</p> <p>The Skin and Weight Review document dated 3/1/24, indicated the Administrator, who was a licensed clinical professional, signed the Clinical section, but the area was left blank. The Skin and Weight Review, dated 5/31/24, the Clinical area was left blank. Only the Dietary Manager filled out the Dietary section on 5/31/24 and indicated to Continue with the current plan of care. Note: By the Dietary Manager documenting, Continue with the current plan of care, and Add to weekly weights, the Dietary Manager, who was not a licensed healthcare professional, was giving recommendations for Resident 29's Nutritional plan of care. On 5/10/24, the Dietary Manager did not fill out the Dietary section, so there was no indication of average meal intake and average supplement intake.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation of a Skin and Weight review occurring for Resident 29, who was still losing weight on 5/3/24, 5/17/24/ and 5/24/24. The Dietary Manager indicated Resident 29 was drinking on average 0-25% of her supplement on 4/1/24, on average 25-50% on 2/24/24, 3/1/24, and 5/31/24, on average 50-75% on 3/8/24 and 3/14/24, and on average of 75-100% on 4/19/24, and 4/26/24. Note: There was no accurate system in place for documentation of supplement to know how much supplement a resident consumed. A supplement was documented on the MAR as given (did not indicate how much was consumed) and fluid intake documentation did not detail the type of fluid intake, such as water, supplement, juice, etc. The Dietary manager indicated on 4/19/24 Resident 29's average meal intake was 51-75%, however, a review of Resident 29s Meal Intake from 4/11/24-4/18/24, revealed her meal intake was not documented for 11 of 21 meals.</p> <p>A review of Resident 29's Quarterly Dietary Progress Note, dated 5/8/24, indicated, Resident 29 was eating 25- 50% of her meals, but there was no Skin and Weight Review done by the Dietary Manger, ADON and the RD since 4/26/24, almost 2 weeks ago and a review of Resident 29 Meal Intake, dated 4/26/24-5/9/24, Resident 29 breakfast intake was not documented 11 times, lunch 10 times and one dinner refusal during this time period. The Dietary Manger was documenting Resident 29 lacks the capacity but is alert, her care plans have been reviewed and revised, and will continue with current plan of care. A Dietary Manager, who was not a licensed clinical professional, cannot do assessments and cannot give recommendations.</p> <p>A review of the RD Dietary Progress Notes, indicated the RD reviewed Resident 29's weight loss 2/14/24, 2/18/24, 2/21/24, 4/27/24 and 5/23/24. Note: Resident 29's weight on 3/1/24 was 131.7 lbs. and Resident 29's weight on 4/22/24, seven weeks later, was 118.4 lbs., which indicated a 10.10% weight loss.</p> <p>A review of the RD document titled, Consultant Dietitian Monthly Report, dated 4/18/24, indicated the RD made her quarterly visit that day, but a review of Resident 29's RD Dietary Progress Notes, indicated the RD did not do an in-person assessment to observe why Resident 29 was not eating. The RD's Dietary Progress Note, dated 4/27/24 and 5/23/24, Contributing Factors to Resident 29's weight loss looked identical, no changes and the RD was relying on staff who stated, She just did not eat well, prefers to drink coffee and thinks her food is poisoned, just refuses everything.</p> <p>For the RD to complete a Resident's Nutritional Data Collection due upon admission and yearly, the RD was relying a lot on the documentation of Health Care Personal and the Dietary Manager, which was often incomplete or inaccurate. Reviewing Resident 29's medical record, there was no indication the RD did an in-person assessment on Resident 29.</p> <p>During an interview on 6/19/24 at 8:45 a.m., the ADON stated she was not familiar with the MDS. The ADON stated the Dietary Manager filled out Section K (Swallowing and Nutritional Status) of the MDS. The ADON stated she had nothing to do with the Quarterly Dietary Progress Note and confirmed the Dietary Manager wrote the resident's Quarterly Dietary Note. The ADON stated she along with the Dietary Manager and the RD, who teleworked, and attended by phone, participated in the Weight Variance weekly meetings. The ADON stated she completed the Clinical section of the Skin and Weight Review, but if the resident did not have any skin issues, she did not complete that section.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/19/24 at 1:25 p.m., the Administrator stated the Dietary Manager was just regurgitating what the RD recommended for residents with weight loss/gain and what the resident's physician ordered. When pointing out one of the Dietary Manager's Quarterly Progress Note indicating a recommendation for Resident 12, dated 5/15/24, Resident care plans has been reviewed and revised. Will continue with the current plan of care. The Administrator stated the Dietary Manager did 75% of the resident's care plan and the RD goes after the Dietary Manager, reviews the resident's chart and updates the Resident's 'Nutritional care plan accordingly. The Dietary Manager did the Quarterly Dietary Progress Note by reviewing the resident's chart and inputted the data according to the nurse, RD, and resident's physician's progress notes.</p> <p>During an interview on 6/21/24 at 9:42 a.m., the ADON stated she met with the Dietary Manager and RD every Wednesday for the Weight/Skin Variance but she was way behind inputting her information into the Clinical section of the Skin and Weight Review document.</p> <p>2. A review of Resident 12's Admission Record indicated Resident 12 was admitted on [DATE], with a diagnosis that included paranoid schizophrenia (feeds into delusions believes something that isn't true no matter how much evidence you give to the contrary), and hallucinations (involve the senses: seeing, feeling, or hearing something that isn't there), it's common for them to feel afraid and unable to trust others), chronic pain, borderline personality disorder (a mental illness that severely impacts a person's ability to manage their emotions), altered mental status (acute confessional state), amongst others.</p> <p>A review of Resident 12's Annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 5/15/24, indicated Resident 12 was severely cognitively impaired (causes serious issues with memory and our ability to reason, make decisions or even care for ourselves). Section K: Swallowing/Nutritional Status, indicated Resident 12 was 180 pounds, had lost 5% or more in the last month or 10% or more in the last six months, and Resident 12 was not on physician-prescribed weight-loss regimen.</p> <p>A review of Resident 12's Order Summary Report, dated 6/19/24, indicated Resident 12 the following order: MD (Doctor of Medicine: physician) directed weight loss recommendation from RD. Current BMI (Body Mass Index: BMI screens for weight categories that may lead to health problems, BIM ranging from 18.5 to 24.9 was a healthy weight range) is 26.9 for height and weight. Ideal weight below 200 lbs., (160-190 lbs.), order date 2/21/23.</p> <p>A review of Resident 12's Weights and Vitals Summary,</p> <p>12/10/2022: 219.6 lbs.</p> <p>1/4/2024: 194.3 lbs.</p> <p>2/6/2024: 183.4 lbs.</p> <p>3/4/2024: 180.8 lbs.</p> <p>3/19/2024: 175.9 lbs.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>3/25/2024: 180.6 lbs.</p> <p>4/2/2024: 180.2 lbs.</p> <p>4/8/2024: 180.2 lbs.</p> <p>5/6/2024: 180.2 lbs.</p> <p>A review of Resident 12's Potential Nutritional Risk care plan, initiated on 7/8/2016 by a Dietary Manager and revised on 5/8/24 by the RD. Focus indicated, weight loss past 12 months, desirable likely resident meal consumption, diuresis (an increase in the amount of urine made by the kidney and passed by the body), and per MD: weight goal 160-190 lbs. Current BMI 28.2. Diet No Added Salt (NAS), regular texture, and thin liquids. Supplement: Health shake three times per day. Goals included weight goal: 160-190 lbs., initiated 5/8/24 by the RD. Interventions initiated 7/8/2016 and/or revised 6/2/1018, encourage adequate fluid intake and intake of nutrition, monitor and document intake, nutrition prescription as ordered and weight per orders. Intervention initiated 6/2/18, identify food preferences and try to offer them. Intervention initiated 5/22/23, continue current diet and plan of care.</p> <p>A Review of Resident 12's Skin and Weight Review' dated 3/21/24, 3/29/24, 4/5/24, and 4/11/24, under the Clinical section completed by the ADON, indicated Resident 12 had a Significant Weight Loss, but his weight was 175.9-180.6 lbs., which was within the MD directed weight loss recommendation from the RD and care planned.</p> <p>During a phone interview on 6/13/24 at 3:42 pm., the RD stated she did a Weight Variance meeting with the ADON and Dietary Manager every Wednesday at 1 p.m. They looked over weekly and monthly weight concerns. When asked about Resident 12's Annual Dietary Progress Note, dated 5/15/24, completed by the Dietary Manager, which included Resident 12's BMI, mentioned Resident 12 being on diuretics and anti-psych medication and included side effects, and made a recommendation, Will continue with the current plan of care. The RD stated the Dietary Manager pulled the weights and diagnosis. The RD stated she did not sign for the Dietary Manager. It was pointed out to the RD the Dietary Manager was not a licensed clinical professional and was therefore not qualified to document clinical information or give recommendations for Resident 12.</p> <p>During an interview on 6/18/24 at 10:45 a.m., the RD stated she flew in on Sunday and was at the facility Monday and today (Tuesday). The RD stated she reviewed the resident's weight gain and weight loss [TRUNCATED]</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on observation, interview and record review, the facility failed to monitor one of two sampled residents (Resident 6), who was on continuous oxygen (O2) therapy (supplement O2) at 2 liters (L), portable O2 tank to make sure Resident 6's O2 tank was changed before it ran out of oxygen. This failure resulted in Resident 6's O2 tank running out of oxygen while Resident 6 was in her wheelchair propelling herself in the hallway, which could have led to Resident 6 becoming short of breath, which could have led to respiratory distress, a decline in Resident 6's health and possible hospitalization .</p> <p>Findings:</p> <p>A review of Resident 6's Admission Record, indicated Resident 6 was admitted on [DATE], with a diagnosis including a stroke, high blood pressure, emphysema, chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), shortness of breath, amongst others.</p> <p>A review of Resident 6's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 3/13/24, indicated Resident 6 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. Section O: Special Treatments and Programs, indicated Resident 6 was on Oxygen Therapy.</p> <p>A review of Resident 6's Order Summary Report, dated 6/19/24, indicated Resident 6 had an order for O2 two liters per minute continuous via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) every shift for O2 therapy and history of Shortness of Breath, start date 4/7/2023.</p> <p>During an observation on 6/10/24 at 10:11 a.m., Resident 6 was on portable oxygen at two liters per minute.</p> <p>During an observation on 6/11/24 at 10:10 a.m., Resident 6 was up in her wheelchair propelling herself in the hallway. When the O2 tank gauge was checked, it read oxygen tank was empty.</p> <p>During a concurrent observation and interview on 6/10/24 at 10:32 a.m., Resident 6 was up in her wheelchair propelling herself in the hallway. Resident 6 was asked to stop because her O2 tank gauge was reading empty. Resident 6 stated she could not feel any O2 coming from her nasal cannula. Resident 6 started propelling herself to find her nurse. Licensed Staff B saw Resident 6's portable O2 tank read empty after it was pointed out to her. Licensed Staff B stated any CNA (Certified Nursing Assistant) could tell her if the resident's portable O2 tank needed to be refilled, but ultimately it was her responsibility to make sure a resident's portable O2 tank did not go empty.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 12:33 p.m., the Administrator was asked who was supposed in monitoring a resident's portable O2 tank so the tank did not run empty. The Administrator stated it was the resident's nurse who was responsible in making sure the resident's portable O2 tank did not run empty. The Administrator stated it was out of the CNAs' scope of practice though if a CNA noticed the resident's portable O2 tank was getting low or empty, the CNA could let the nurse know.</p> <p>During an interview on 6/14/24 at 1:15 p.m., the Director of Staff Development (DSD), stated the charge nurses oversaw the resident's O2 therapy.</p> <p>The facility Policy and Procedure titled, Oxygen Therapy, revised 5/15/2021, indicated: . Oxygen is administered under safe and sanitary conditions to meet resident needs. Nursing staff will administer oxygen as prescribed. Procedure: I. Administration of Oxygen: A. Administer oxygen per physician orders .</p> <p>The facility job description titled, Charge Nurse, undated, indicated: .General Duties and Responsibilities: Clinical - . * Administer professional services such as: catheterization, tube feeding, suction, applying and changing dressings/bandages, packs, colostomy and drainage bags, taking blood, sputum, and urine specimens, care of the dead/ dying, etc., as established by the facility's policies and procedures .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27532</p> <p>Based on observation, interview and record review, the facility failed to ensure they had enough staff to:</p> <ol style="list-style-type: none"> <li>1. Promptly respond to call lights of 4 of 24 sampled residents (Resident 35, Resident 3, Resident 25, and Resident 50), and one unsampled resident (Resident 40) causing residents to wait long periods of time.</li> <li>2. To meet the ADLs (Activities of Daily Living: are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and assisted with eating or needing to be fed) needs of the residents, including Resident .</li> <li>3. To provide prompt incontinence care (cleaning the private areas of residents with loss of bowel and bladder function) to one of 24 sampled resident (Resident 14) and discharged Resident 232.</li> </ol> <p>This failure resulted in:</p> <ol style="list-style-type: none"> <li>1. Resident 35 lying in his soiled linen to get cleaned, Resident 3 burning her skin and feeling bothered, Resident 25 feeling bad and awful, Resident 50 screaming for help and getting mad, and Resident 40 feeling like the staff just did not like taking care of the residents and were just working for a paycheck.</li> <li>2. This resulted in residents having to wait to be fed and their lunch becoming cold, a resident having to wait to be transferred back to bed, residents not getting their brief checked and changed every two hours, a blind resident having to eat with her fingers, staff having to feed more than one resident at a time, which could have caused cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another), and the potential for unsafe transfers, which could lead to harm.</li> <li>3. Injury to the skin of Resident 232, and feelings of shame and frustration for Resident 14.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an interview on [DATE], at 10:57 AM, Resident 35 stated he had to wait two hours for assistance because staff had called off (did not come to work). Resident 35 stated four of seven days a week he had to wait to be cleaned.</li> </ol> <p>A review of Resident 35's annual MDS (Minimum Data Set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated [DATE], indicated he was cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15, had not rejected assistance with activities of daily living, was dependent for maintaining perineal hygiene, required maximal assistance to roll from lying on back to left and right side, occasionally unable to control urination and frequently had no control with bowel movement.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE], at 11:58 AM, Resident 3 stated it took as long as four to six hours for staff to respond to calls for assistance. Resident 3 stated she had experienced lying in her urine and feces while waiting. When asked how she felt, Resident 3 stated it burned her skin and bothered her when she was made to lie in her urine and feces and wait for assistance.</p> <p>A review of Resident 3's quarterly MDS, dated [DATE], indicated she has memory problems but able to recall her room location.</p> <p>During an interview on [DATE], at 2:24 PM, Resident 25 stated she had a hard time getting someone to help her. Resident 25 stated she felt so bad and awful waiting two to three hours to get cleaned. Resident 25 stated this happened three to four times a week.</p> <p>A review of Resident 25's quarterly MDS, dated [DATE], indicated she had long term memory problem but able to recall the season, the location of her room and that she is in a skilled nursing facility.</p> <p>During an interview on [DATE], at 2:26 PM, Resident 50 stated she sat in the rest room waiting to be cleaned more than an hour once or twice a month, she had screamed for help and was so mad.</p> <p>A review of Resident 50's 5-day scheduled assessment MDS, dated [DATE], indicated she was cognitively intact with a BIMS score of 15.</p> <p>During an interview on [DATE] at 6:02 p.m., Resident 40 stated he did need assistance transferring from his wheelchair to the toilet. Resident 40 stated a CNA (Certified Nursing Assistant) would come into his room, turn off his call light, and then he would wait ten minutes to one hour. Resident 40 stated he would use the call light because he needed to be transferred to use the bathroom either to urinate or have a bowel movement. Resident 40 stated her wore a brief too. Resident 40 stated the staff should be at the facility to take care of us, the residents, but many he feels were just working for a paycheck. Resident 40 repeated, Really feels like staff were just here for the paycheck.</p> <p>A review of Resident 40's Quarterly MDS, dated [DATE], indicated Resident 40 had a BIMS score of 15, cognitively intact.</p> <p>35842</p> <p>2. During a Total Assisted Dining (TAD) Room observation, on [DATE] at 12:18 p.m., there were three staff members (Unlicensed Staff C, Unlicensed Staff E and a nurse) to assist or feed eight residents. Unlicensed Nurse E was wearing gloves while he was feeding Resident 4 to his left and Resident 2 to his right. Resident 227 had just arrived at the TAD Room and room was made for her to sit at the table next to Resident 2. Unlicensed Staff E, who was wearing gloves while feeding the resident on his left and the resident on his right, stopped feeding the two residents and went to help Resident 227 cut her meat while wearing the same gloves. Unlicensed Staff E went back to feeding Resident 4 and Resident 2 without changing his gloves.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on [DATE] 12:18 p.m. in the Assisted Dining Room, eight residents were either being totally assisted or set-up and assisted as needed. Unlicensed Staff C was feeding Resident 52, who was a total assist. Resident 55 was sitting at the table next to Resident 52 waiting to be fed while the seven other residents were either being fed or had been set-up and were feeding themselves.</p> <p>During an observation [DATE] at 12:40 p.m., Unlicensed Staff C was done feeding Resident 52 and was just starting to feed Resident 55, 22 minutes later. Unlicensed Staff C had to heat up Resident 55's food in the microwave because Resident 55's hot food had gotten cold while waiting 22 minutes to be fed.</p> <p>During a concurrent observation and interview on [DATE] at 11:23 a.m., Resident 12 was dressed and sitting up in his wheelchair next to his bed. Resident 12 stated he had been up and dressed since breakfast. Resident 12 stated he had gone to the Main Dining Room for breakfast, which he stated he liked. Resident 12 stated he thought it was around 8 a.m. when he had his breakfast in the Main Dining Room. Resident 12 stated he had been waiting an hour for assistance back to bed. Resident 12 stated he had not been changed since he got up, which he thought was around 8 a.m. (3 ,d+[DATE] hours ago). Resident 12 had a Hoyer lift (a device designed to assist caregivers in safely transferring patients) pad under him, which looked uncomfortable.</p> <p>During an interview on [DATE] at 1:05 p.m., Unlicensed Staff M stated Resident 12 had been up since 6:30 a. m. Unlicensed Staff M stated Resident 12 had been assisted up early so he could go down to the Main Dining Room for a special Country breakfast. Resident 12 had been up for five hours and his brief had not been changed for at least five hours. Unlicensed Staff M stated she did ask Resident 12 if he wanted to go back to bed after breakfast but he had not wanted to go back to bed yet. Note: Resident 12's breakfast time was 7 a.m., which was the time the residents in the Main Dining Room were fed.</p> <p>During an observation on [DATE] at 12:40 p.m., there were two staff members (Unlicensed Staff C and a nurse) for nine residents in the TAD Room. Resident 29 was trying to communicate in Spanish but was being ignored. The staff in the TAD Room did not speak Spanish, so staff could not understand Resident 29 in order to meet her dining needs. Unlicensed Staff C nor the nurse got someone to communicate with Resident 29 in Spanish. Resident 29 was legally blind and no staff member was sitting next to Resident 29 to guide her on where her food was on her plate. Unlicensed Staff C and the nurse were both sitting at the other end of the table feeding a resident. Unlicensed Staff C did place a plate guard (helps prevent food from accidentally being pushed off the plate while eating, minimizing spills at mealtime) on Resident 29's plate and handed her a fork. Resident 29 started eating her pasta with her fingers and still no one came over to sit next to Resident 29 to guide her with using her fork and with the placement of food items on her plate. Resident 29 was not offered a washcloth after she ate her pasta with her fingers.</p> <p>During an interview on [DATE] at 1:10 p.m., Unlicensed Staff D stated he has had up to ,d+[DATE] residents on the PM shift. Unlicensed Staff D stated at times he could not answer his resident's call lights in a timely manner because he may be assisting another resident. Unlicensed Staff D stated residents have complained to him about having to wait. Unlicensed Staff D could not give a time for how long he kept a resident waiting. It would vary. Unlicensed Staff D stated if he was helping a resident and went to get linen, briefs, etc. for the resident and he saw a call light on, he would not answer the call light because that would be like abandoning the other resident he was tending to.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 2:30 p.m., Unlicensed Staff C stated she did assist in the TAD Room on Monday, [DATE], but was pulled to the [NAME] Hall and assigned Rooms ,d+[DATE] (13 residents) because the facility was short staffed a CNA.</p> <p>During an interview on [DATE] at 10:15 a.m., the Administrator stated the AM shift started at 6:30 a.m. to 3 p. m., the PM shift started at 2:30 p.m. to 11 p.m. and Night shift started at 10:30 p.m. to 7 a.m. The Administrator stated nurses &amp; CNAs (Certified Nursing Assistance) scheduled whereas follows: On the AM shift there were three nurses for the three medication carts, the Director of Nursing (DON), the Assistant DON and six to nine CNAs, who took a total of nine to twelve residents. On the PM shift there was a RN (Registered Nurse) and two LVN (Licensed Vocational Nurses) and normally five to eight CNAs. On the Night shift there was two nurses scheduled. If one nurse called off, there would only be one nurse working on the Night shift, but then another nurse would come in around 3 a.m. or 4 a.m. to help pass the Night shift medications. The Night shift would have four CNAs.</p> <p>During an interview on [DATE] at 12:05 p.m., Anonymous Witness J stated, the Night shift nurse was usually the only nurse on the Night shift. Anonymous Witness J stated at times one CNA (Certified Nursing Assistant) would transfer a resident using the Hoyer lift (a patient lift used by caregivers to safely transfer patients) because of being short staffed (No one else to help). Anonymous Witness J stated there was never a huddle with the traveling nurses at the beginning of the shift to find out about their residents, such as who was on fall precautions and residents who had a Change in Condition. Anonymous Witness J stated there was a lot of dehydration issues with the residents because of being short staffed. Anonymous Witness J stated he/she had 14 residents, two showers and one feeder. Anonymous Witness J stated he/she tried to make three rounds during his/her shift to change the residents' brief but it was not always possible because of the assignment.</p> <p>During an interview on [DATE] at 11:08 a.m., the DON (Director of Nursing) stated she was working on the floor on [DATE] because they were short staffed. The DON stated she worked on the floor the Saturday before Mother's Day, which was [DATE] and she worked on Monday, [DATE] and Tuesday, [DATE] because they were short staffed a nurse. The DON stated she then stayed over to get some of her DON duties completed.</p> <p>39621</p> <p>3. Record review indicated Resident 232 was admitted to the facility on [DATE] with medical diagnoses including Septic Shock (A widespread infection causing organ failure and dangerously low blood pressure), according to the facility Face Sheet (Facility demographic).</p> <p>Record review of Resident 232's MDS (Minimum Data Set-An assessment tool) dated [DATE] indicated he was completely dependent on staff for toileting hygiene and personal hygiene.</p> <p>Record review of Resident 232's progress note dated [DATE] at 1:20 p.m. indicated Resident 232 would be returning to the facility from a General Acute Care Hospital (GACH) at around 1:30 p.m., on that same day.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 9:30 a.m., Family Member N stated Resident 232 was left with a soiled disposable brief for more than 48 hours after he returned to the facility from the GACH, which severely burned his skin, and caused him excruciating pain on the last days of his life. According to Family Member N, Resident 232 died within a week or returning from the GACH. Family Member N stated he discovered he was left with the same disposable brief because in the GACH they used a different type of disposable briefs as in the facility, and two days after Resident 232 had returned to the facility from the GACH, he was still wearing the same diaper he came back to the facility with.</p> <p>Record review of Resident 232's ADL flow sheets for January of 2024, indicated he received incontinence care on [DATE] at 9:01 p.m., after he returned from the GACH (If he returned from the GACH at 1:30 p.m., as the progress note dated [DATE] at 1:20 p.m., indicated, Resident 232 did not receive incontinence care until 7.5 hours after he returned from the GACH). According to this document, on [DATE] Resident 232 received incontinence care at 12:37 a.m. (More than 3.5 hours after the last episode), 1:59 p.m. (More than 13 hours after the last episode), and at 9:59 p.m. (8 hours after the last episode). On [DATE], the flow sheet indicated Resident 232 received incontinence care at 1:14 a.m. (More than 3 hours after the last episode), 1:59 p.m. (More than 12 hours after the last episode), and at 9:59 p.m. (8 hours after the last episode). The ADL flow sheets for [DATE] also indicated the following, Check on resident every 30 minutes and address hydration, repositioning, skin care, oral care . This flow sheet indicated that on [DATE], these services were provided at 1:14 a.m., 3:00 a.m. (More than 1.5 hours after the last episode), 4:00 a.m. (1 hour after the last episode) and hourly thereafter until 9:00 p.m. After 9:00 p.m., these services were not provided until the following day at 1:47 a.m. (More than 3.5 hours after the last episode).</p> <p>Record review of a facility document titled, Admission Nursing Evaluation, dated [DATE] at 2:26 p.m., indicated that after he returned from the GACH, Resident 232's only skin injuries were on the chest area, where a bruise and skin tear were noted.</p> <p>Record review of a facility document titled, Weekly Skin check and Wound Assessment, dated [DATE] at 12:28 p.m., indicated Resident 232 had developed, Redness with coccyx (The lower back area, at the bottom of the spine) as well .Bilateral (Both) legs discolored purple in color.</p> <p>Record review of a progress note dated [DATE] at 7:15 p.m., indicated Resident 232 passed away on [DATE] at 6:30 p.m.</p> <p>During an interview on [DATE] at 10:06 a.m., the Director of Nursing (DON) confirmed Resident 232's brief was left soiled for an extended period of time which damaged the skin, after his hospital visit. The DON stated not knowing exactly for how many hours the disposable brief was left on.</p> <p>During a phone interview with Anonymous Witness O on [DATE] at 4:15 p.m., he/she stated having worked for the facility, and taken care of Resident 232 before he passed away. Anonymous Witness O stated that when Resident 232 returned from the GACH (on [DATE]) his disposable brief was not changed for at least 12 hours. Anonymous Witness O stated Resident 232's skin on his perianal area was beyond excoriated, every time they tried to wipe it would bleed, from the damage suffered for having left the disposable brief on his body for too long. Anonymous Witness O stated that when he/she worked for the facility as a Certified Nursing Assistant, he/she was assigned up to 20 residents during the morning shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review indicated Resident 14 was admitted to the facility on [DATE] with medical diagnoses including Obesity, and Urinary Tract Infections, according to the facility Face Sheet.</p> <p>Record review of Resident 14's MDS (Minimum Data Sheet-An assessment tool) dated [DATE] indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 15, which indicated her cognition was intact (A score of ,d+[DATE] indicates the cognition is severely impaired, ,d+[DATE] indicates the cognition is moderately impaired, and ,d+[DATE] indicates the cognition is intact). Record review of Resident 14's MDS dated [DATE] also indicated Resident 14 was completely dependent on staff for toileting hygiene and required maximal assistance with rolling left and right in bed.</p> <p>Record review of Resident 14's care plan for incontinence care initiated on [DATE] indicated she was incontinent of bowel and bladder.</p> <p>During an interview on [DATE] at 10:41 a.m., Resident 14 stated being very concerned about staffing. Resident 14 stated the facility did not have enough staff, and for that reason, she did not get enough help. Resident 14 stated she was left in her wet or soiled disposable brief for more than 2 hours, and was not repositioned often either, it took more than 2 hours for staff to reposition her in bed. Resident 14 stated she had developed urinary tract infections at the facility, and believed they were related to the lack of incontinence care provided to her.</p> <p>Record review of Resident 14's ADL flowsheets for [DATE], indicated Resident 14 received incontinence care during one of three shifts (Each shift is 8 hours) in 24 hours on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] &amp; [DATE]. This flowsheet also indicated that on 16 out of 31 days she was repositioned only once, during a 24-hour period, and on 15 out of 31 days, she was not repositioned at all during each 24-hour period (On ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], 520, ,d+[DATE], ,d+[DATE], ,d+[DATE] &amp; [DATE]).</p> <p>Record review of Resident 14's ADL flowsheets for June ([DATE]st through [DATE]th), 2024, indicated Resident 14 received incontinence only during evening shift on the following days: ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]. Similarly, documentation indicated she was repositioned only once in bed during a 24-hour period on [DATE], [DATE] and [DATE].</p> <p>During a concurrent interview and record review with the Director of Staff Development (DSD) on [DATE] at 10:30 a.m., she reviewed Resident 14's ADL flowsheets for May and June, 2024 and confirmed the documentation indicated Resident 14 was only provided incontinence care one shift per day and was repositioned only one time a day on several days. The DSD stated incontinence residents were supposed to be checked every two hours.</p> <p>During an interview on [DATE] at 11:07 a.m., Anonymous Staff Q (Unlicensed Staff) stated he/she was assigned 16 residents for morning shift, and that was the norm. Anonymous Staff Q stated sometimes he/she was assigned more than 16 residents for morning shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Anonymous Witness J on [DATE] at 4:15 p.m., he/she stated nursing assistants were assigned 16 to 20 residents per shift, which did not provide them enough time to perform all ADLs and supervise residents at risk for falls. Anonymous Witness J stated he/she felt like certified nursing assistants were neglecting residents because they did not have time to provide all the care and services the residents needed.</p> <p>During an interview on [DATE] at 10:16 a.m., Unlicensed Staff C stated she was employed as a Rehabilitative Nursing Assistant (Certified Nursing Assistant with special training in therapy and rehabilitation services) but was frequently assigned to work as a Certified Nursing Assistant on the floor (with resident assignments) because the facility was short-staffed.</p> <p>During an interview on [DATE] at 10:17 a.m., the DON stated she felt the facility needed more staff.</p> <p>During an interview on [DATE] at 10:50 a.m., Resident 40 stated he had observed residents vomiting and being allowed to stay with their soiled clothing for hours without staff changing them. He also stated he had been left sitting in his soiled undergarments for more than two hours and felt this was not respectable. Resident 40 stated this was in part due to the facility not having enough staff.</p> <p>During an interview on [DATE] at 9:57 a.m., Resident 52 stated the facility was short staffed for Certified Nursing Assistants and Licensed Nurses.</p> <p>During an interview with the Social Services Director on [DATE] at 6:26 p.m., she stated she was informed they were admitting a new resident. Despite being extremely short staffed (based on evidence above) to take care of their current residents, the facility continued to admit new residents.</p> <p>A review of the facility's policy titled: Resident rights, version no. 1.0, dated [DATE], indicated: the facility will promote and protect the rights of all residents at the facility. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.</p> <p>The facility Policy &amp; Procedure (P/P) titled, Feeding the Resident, revised [DATE], indicated: Purpose: Residents able to receive oral feedings are properly positioned to facilitate eating. Assistance is provided with eating for residents as needed . IV. Nursing Staff will assist with serving the trays and feeding residents as needed .</p> <p>The job description titled, CNA, undated, Position Description: A nursing assistant responsible for providing routine nursing care in accordance with established policies and procedures and as may be directed by the Charge Nurse, RN Supervisor, Director of Nurses or Administrator, to assure that the highest degree of quality resident care can be maintained at all times General Duties and Responsibilities: General: *Perform all duties as assigned and in accordance with facility's established policies and procedures, nursing care procedures and safety rules and regulations. *Make resident rounds at the beginning of each shift and every two hours thereafter to administer quality nursing care . * Feed residents who cannot feed themselves. o Assure that resident's food is accessible and self-help devices are available as needed . *Keep incontinent residents clean and dry as possible at all times. Change bed linens, diapers, and clothing as often as necessary .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure the temperatures of 2 of 2 medication refrigerators (Refrigerator A and Refrigerator B) in the medication room of the facility, were within normal range to store resident insulins (Injectable medication to lower blood sugar levels) and COVID-19 vaccinations, among other medications. In addition, two expired medications were found stored with active medications in the medication room and one of the medication carts of the facility. This finding had the potential to result in medications and immunizations that were no longer effective, causing harm to the residents involved.</p> <p>Findings:</p> <p>During a concurrent medication storage observation and interview with Licensed Staff A on 6/20/24 at 11:45 a.m., the temperature of Refrigerator A (inside the medication room of the facility) was 52 degrees Fahrenheit. This refrigerator stored 8 pens of Lantus insulin (Long-acting medication to lower blood sugar levels) labeled with residents' names and a Prevnar vaccine (A pneumococcal vaccine that protects against serious illnesses caused by Streptococcus pneumoniae bacteria). Licensed Staff A confirmed the Lantus pens were for resident medication administration. Refrigerator B's temperature (inside the medication room) was 50 degrees Fahrenheit and stored 2 vials of COVID-19 Pfizer vaccine (Vaccine to protect against the COVID-19 disease) and an emergency kit. Licensed Staff A confirmed these medications were for resident use. In addition, an expired bottle of fish oil capsules was found in the medication room stored with other active medications. The expiration date was, 05/24. Licensed Staff A confirmed the finding.</p> <p>Record review of an untitled form posted on the wall of the medication room indicated, REFRIGERATOR TEMPERATURE NEEDS TO MAINTAIN 36-46 F (36 to 46 degrees Fahrenheit).</p> <p>Record review of a temperature log posted on the wall of the medication room titled, TEMPERATURE OF MEDICATION REFRIGERATORS, indicated that on 6/09/24 during the day shift, the temperature of refrigerator B was 47 degrees Fahrenheit. The temperature was also recorded as 47 degrees Fahrenheit on 6/10/24 during night shift.</p> <p>During a concurrent interview and observation with the Maintenance Director on 6/20/24 at 12:01 p.m., the temperatures of both refrigerators were checked again, and both refrigerator temperatures were 50 degrees Fahrenheit, which was confirmed by the Maintenance Director. The Maintenance Director was asked, if, within the last 30 days, he had been notified the temperature in these refrigerators was above normal ranges. The Maintenance Director stated he had not been notified, but he would adjust the temperature dials right away.</p> <p>During an observation and interview on 6/20/24 at 12:20 p.m., the medication cart in the east hallway was checked with Licensed Staff L. A bottle of medication Glucosamine Chondroitin (A supplement that helps maintain cartilage health) was found in the medication cart stored with other active medications. This bottle had an expiration date of, 05/24. This was confirmed by Licensed Staff L.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled, Storage and Expiration of Medications, Biologicals, Syringes and Needles, last revised on 1/01/13, indicated, Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis.</p> <p>40254</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</b></p> <p>Based on interview and record review the facility failed to provide dental services for one of 23 sampled residents (Resident 33) who needed to see an oral [NAME] for a revisit. This failure had the potential for Resident 33 to experience intermittent oral pain, problems with eating, speaking and infections of the mouth if Resident 33's oral surgeon appointment was missed and decrease Resident 33's optimal physical, social, mental and psychosocial well-being.</p> <p>Finding:</p> <p>A review of Resident 33's Admission Record indicated Resident 33 was admitted on [DATE], with a diagnosis including stroke, hemiplegia (paralysis that affects only one side of the body) affecting the left side, dysphagia (difficulty in swallowing), delusional disorder (a mental disorder), bipolar disorder (a mental disorder), amongst others.</p> <p>A review of Resident 33's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 3/12/24, indicated Resident 33 was severely cognitive impaired (never/rarely made decisions) and L Section: Oral/Dental Status: indicated: mouth and facial pain, discomfort, or difficulty with chewing.</p> <p>A review of Resident 33's care plan, indicated Resident 33 had a Oral/Dental Health Problems care plan, initiated On 1/17/22 caused by poor oral hygiene.</p> <p>During a concurrent interview and record review on 6/11/24 at 10:33 a.m., Social Services was asked about a Dental Progress Note, dated 3/14/24, indicated Resident 33 needed to see the oral surgeon and assistance with oral care. Social services stated she recalled seeing the Dental Progress Note but Social Services stated she needed an authorization from Resident 33's medical insurance. Social Services stated Resident 33 would have to go to the oral surgeon in (name of town about 150 miles away) because the surgeon in town did not take Resident 33's medical insurance. Social Services stated she would have to look through her notes, and at this time, no appointment had been made. Social Services stated she really tried to be proactive with all the residents but resources were difficult to locate in the area. Social Services stated only certain counties took Resident 33's medical insurance without authorization. Social Services stated Resident 33 saw an oral surgeon on 3/15/24. Social Services stated no documentation came back with Resident 33 and there had been no follow-up from Social Services with the oral surgeon.</p> <p>During a concurrent interview and record review on 6/12/24 at 11:39 a.m., Social Services stated she did find her note indicating Resident 33 needed a three-month follow-up appointment with the oral surgeon. Social Services showed Resident 33's Alert Charting note, dated 3/15/24, indicated Resident 33 returned from the physician's office and was to return in three months. Social Services stated she called today and made a follow-up appointment for Resident 33 with the oral surgeon. Resident 33's oral surgeon follow-up appointment was not made until after Resident 33's Dental Progress Note, dated 3/14/24 was brought to Social Services attention indicating Resident 33 needed to see oral surgeon, three months after her first visit with the oral surgeon.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Policy and Procedure titled, Oral Healthcare and Oral Services, revised 1/1/21, indicated: Purpose: To the provision of both routine and emergency dental care to all residents at the Facility. Policy: The Facility will provide oral healthcare and dental services as required and needed by each resident. Procedure: .III. Dental Services: . C. The Facility will assist residents in obtaining routine and 24-hour emergency dental care . IV. Assisting Residents With Dental Appointments: A. The Social Services Department (or its designee) is responsible for making the necessary dental appointments. B. All requests for routine and emergency dental services should be directed to the Social Services Department to ensure that appointments are made in a timely manner . V. Documentation: A. Records of dental care provided are maintained in the resident's medical record. B. A copy of the resident's dental record will be provided to any facility to which the resident is transferred .</p> <p>The facility job description titled, Social Service Coordinator Designee, undated, indicated: . Principle Responsibilities: Clinical/Administrative - *Ensure the residents' psychosocial and concrete needs are identified and met in accordance with federal, state and company requirements . *Maintain records of outside referral . * Communicate needs and plan of care to resident, families, responsible parties and appropriate staff .</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure 18 of 81 residents at the facility (Resident 41, Resident 7, Resident 28, Resident 13, Resident 45, Resident 2, Resident 29, Resident 38, Resident 23, Resident 229, Resident 128, Resident 39, Resident 227, Resident 231, Resident 6, Resident 34, Resident 16 &amp; Resident 62) were served their prescribed diets without errors, by dietary staff when errors were noted prior to the trays being delivered to the residents. In addition, Licensed Nurses were observed checking only the trays of residents eating in the social dining room, but no Licensed Nurses were observed checking the trays of the residents eating in their rooms. These failures had the potential to result in nutritional problems and episodes of choking for the residents involved, which could have resulted in death.</p> <p>Findings:</p> <p>During a tray line observation on 6/12/24 from 11:45 a.m. to 1:20 p.m., the Surveyor reviewed every tray ticket and compared it to the actual meal served in each tray for all residents of the facility, after dietary staff had checked them, and were ready to distribute them outside the kitchen. Residents on fortified diets (A diet that includes foods that have been modified to increase their nutritional value) whose diets were missing the butter (this was the only product used in this kitchen to fortify residents' meals):</p> <p>Resident 41</p> <p>Resident 7</p> <p>Resident 28</p> <p>Resident 13</p> <p>Residents on mechanical soft diets (Soft diets for easy chewing) whose diets were not mechanical soft, since they received large chunks of hard melon greater than 1/2 inch in size (Confirmed by the Dietary Manager on 6/12/24 at 12:10 p.m.):</p> <p>Resident 41</p> <p>Resident 45</p> <p>Resident 2</p> <p>Resident 29</p> <p>Resident 38</p> <p>Resident 23</p> <p>(continued on next page)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 229</p> <p>Resident 128</p> <p>Resident 39</p> <p>Resident 227</p> <p>Resident 231</p> <p>Resident 6</p> <p>Resident 34</p> <p>Resident 16</p> <p>Resident 62</p> <p>Record review of the facility spreadsheet for Wednesday 6/12/24 indicated the mechanical soft diets were to receive fresh melon for lunch that was, 1/2? (half an inch in size)-Soft-no skin.</p> <p>During an observation on 6/12/24 at 1:22 p.m., the last meal cart left the kitchen with a taste tray inside of it. This cart was taken to the south hallway of the facility, closest to the Administrator's office, followed by the Surveyor. In this hallway, no Licensed Nurses were observed checking the trays prior to the delivery of the meals to the residents. Certified Nursing Assistants were observed delivering the meals without checking that the trays matched the tray tickets. If the Surveyor had not noted the errors above, while the trays were still in the kitchen, most the likely the trays would have been delivered to the residents with errors.</p> <p>During an interview with the Director of Nursing (DON) on 6/21/24 at 10:17 a.m., she stated that if residents were not provided with the right diet consistency, they could choke with their food.</p> <p>Record review of the facility policy titled, FORTIFIED MENU PLAN, dated 2023, indicated, The Facility Registered Dietitian may modify the Fortified Menu Plan to meet both the individual resident and facility needs. This plan provides an additional 300-400 calories and 3-4 grams of protein per day.</p> <p>Record review of the facility policy titled, Inservice: Modified Diets, dated 3/2022 indicated, The FNS (Food and nutrition services) Department is responsible for the correct delivery of all diets to help provide the highest quality of life for each resident .Meals offered should follow the recipes and spreadsheets . Mechanical Soft Diet: This diet is designed for residents who experience chewing or swallowing limitations . The regular diet is modified in texture with meats and raw fruits and vegetables to be soft, chopped, or ground for ease in chewing.</p>		

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  06/21/2024
NAME OF PROVIDER OR SUPPLIER  Crescent City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1280 Marshall Street Crescent City, CA 95531	
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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>39621</p> <p>Based on interview and record review, the facility failed to ensure four of four kitchen staff (Dietary Aid R, Dietary Aid S, Dietary Aid T, and Dietary Aid U) were knowledgeable of the cooling process for leftover food, thawing process for frozen food, and 3-step process to manually wash, rinse, and sanitize dishware correctly. These findings had the potential to result in foodborne illnesses and spread of infections to all residents of the facility except for Resident 64, who did not eat by mouth.</p> <p>Findings:</p> <p>During an interview on 6/11/24 at 8:50 a.m., with the Dietary Manager present, Dietary Aid R was asked about the 3-step process to manually wash, rinse and sanitize dishware. According to Dietary Aid R, dirty dishes should initially be placed on a tray with soap and sanitizing solution. From there, the dishes should be placed on a second tray with water only, and no sanitizing chemicals. According to Dietary Aid R, the third tray should contain water only, no chemicals, to rinse the dishes. Dietary Aid R stated he started working for the facility in 2022, and on one occasion, they were out of electricity and had to use the 3-step process to wash, rinse and sanitize the dishes. Dietary Aid R stated he received training on this process one time, using an online platform.</p> <p>During an interview on 6/12/24 at 10:30 a.m., Dietary Aid S who was observed cooking the food for lunch on 6/11/24, was asked about the cooling process for leftover food. Dietary Aid R stated she had started working in the kitchen a little bit over a month ago and was not familiar with that policy.</p> <p>During an interview on 6/13/23 at 11:45 a.m., Dietary Aid T was asked about the cooling process for storing leftover food, and the thawing process for frozen food. Dietary Aid T was unable to describe either of the two processes.</p> <p>During an interview on 6/14/24 at 2:15 p.m., Dietary Aid U was asked about the cooling and thawing processes. Dietary Aid U had been previously observed cooking lunch on 6/10/24 for the residents. The Dietary Manager was present during this interview. Dietary Aid T was unable to describe either of the two processes.</p> <p>During an interview on 6/20/24 at 4:23 p.m., the Dietary Manager stated the RD had just trained dietary staff the week of 6/17/24 on the 3-step system to wash, rinse and sanitize dishware manually, the thawing process, and the cooling process. The Dietary Manager stated he had gone over these trainings before with staff but had no documentation of it.</p> <p>Record review of the facility policy titled, 3-COMPARTMENT PROCEDURE FOR MANUAL DISHWASHING, dated 2023 indicated, The first compartment is for washing. Fill the first compartment with detergent per manufacturer's instructions and hot water .The second compartment is for rinsing .The third compartment is for sanitizing .ad (blank) oz (ounces) of (blank) sanitizer. Mix.</p> <p>The policy referencing the thawing process for meats and food was requested but not provided.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility document titled, [Name of Facility] Dietary, indicated, Dietary Staff at [Name of Facility] does not use a Cool Down Log because we don't save any leftovers from meals.</p> <p>During a concurrent observation and interview on 6/10/24 at 8:50 a.m., a plastic bag with cooked chicken was found in the walk-in refrigerator. This chicken had a label that indicated, WED (Wednesday) .6-5. It did not indicate if 6/05 was the prepared date or used by date. Dietary Aid U stated it was the prepared date. This contradicted the facility document titled, [Name of Facility] Dietary, which indicated they did not save any leftovers from meals.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to offer attractive and palatable meals to 80 of 81 residents (All residents of the facility except for Resident 68 who used formula feedings [liquid formula delivered directly into a person's stomach through medical equipment]). The food was noted to be lacking flavor, and the vegetables were previously frozen and then overcooked, leading to loss of nutritive value. This failure had the potential to result in weight loss issues, malnutrition and low quality of life to the residents of the facility as food and drinks were attractive, palatable and served at appetizing temperature.</p> <p>Findings:</p> <p>During an interview on 6/10/24 at 9:58 a.m., Resident 11 stated that the food had no flavor and was often served cold.</p> <p>During an interview on 6/10/24 at 10:41 a.m., Resident 14 stated that the food had no flavor, was served cold, and the meals were odd in the sense that entrees that were not supposed to be served together, were served together.</p> <p>During an interview on 6/10/24 at 10:57 a.m., Resident 229 stated she had concerns about the food. Resident 229 stated the food was usually cold, and the breakfast eggs were hard.</p> <p>During an interview on 6/10/24 at 11:02 a.m., Resident 44 stated that he always received decaffeinated coffee when he liked regular coffee. He also stated the food was often cold and not flavorful.</p> <p>During a taste tray observation and interview with the Dietary Manager on 6/12/24 at 1:30 p.m. in the conference room, with two Surveyors present, the regular and pureed food was tasted. The temperatures of the regular meal entrees were the following (Temperatures taken by the Dietary Manager):</p> <p>Pasta: 117 degrees Fahrenheit</p> <p>Vegetables: 96 degrees Fahrenheit.</p> <p>Bread: Temperature not taken; the temperature appeared to be room temperature.</p> <p>Pureed Meal:</p> <p>Pasta: 94 degrees Fahrenheit.</p> <p>Vegetables: 93 degrees Fahrenheit.</p> <p>Pureed bread: 95 degrees Fahrenheit.</p> <p>Fluids:</p> <p>Cranberry juice: 50 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Orange juice: 46 degrees Fahrenheit.</p> <p>During the observation, the vegetables tasted as having been frozen, appeared overcooked (mushy, soft, and starting to lose their original shape), and had no pleasant flavor at all. This was confirmed by a second Surveyor who also tasted the food. This was true of both the regular meal and the pureed meal. The Dietary Manager confirmed the vegetables were overcooked but stated that the residents liked them that way. The Dietary Manager confirmed the vegetables had been frozen.</p> <p>Record review of the facility policy titled, Inservice: Modified Diets, dated 3/2022, indicated, Meals offered should follow the recipes and spreadsheets and be served in a manner that ensures they are nutritious, attractive, and palatable.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39621</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident food was stored, prepared, and served in a sanitary manner when the kitchen was found not clean, unorganized, containing expired, spoiled and moldy food items, and lacking documentation for the food thermometer calibration log. These failures had the potential to result in foodborne illness and spread infections to 80 of the 81 residents living at the facility, with the exception of Resident 68, who received formula feedings (liquid nutrition delivered to the resident directly to the stomach using specialized medical equipment).</p> <p>Findings:</p> <p>During an initial observation and concurrent interview with Dietary Aid U, starting on [DATE] 8:45 a.m., there were multiple findings in the kitchen of the facility as follows (Photographs were taken):</p> <ol style="list-style-type: none"> <li>[DATE] at 8:46 a.m.: In the walk-in refrigerator, two strawberries that were covered with a thick layer of white mold were found. They appeared to be wrapped in a layer of soft cotton. Dietary Aid U confirmed the finding and took the strawberry box away.</li> <li>[DATE] at 8:48 a.m.: In the walk-in refrigerator a bag of chopped celery that was undated/unlabeled was found. Unknown when it was prepared, or when the used by date was. This was confirmed by Dietary Aid U. Some celery pieces were starting to turn brown, which indicated they were starting to go bad.</li> <li>[DATE] at 8:49 a.m.: A zip lock bag with chopped tomato had the date [DATE] written on it but did not indicate if this was the prepared date or used by date. The tomatoes were soft, mushy, soggy, and appeared to be spoiled. Dietary Aid U confirmed the finding and stated everything should be labeled with the opened or prepared date and used by date.</li> <li>[DATE] at 8:50 a.m.: A plastic bag with cooked chicken was found in the walk-in refrigerator. This chicken had a label that indicated, WED (Wednesday) XXX,d+[DATE]. It did not indicate if ,d+[DATE] was the prepared date or used by date. Dietary Aid U stated it was the prepared date.</li> <li>[DATE] at 8:50 a.m. A plastic bag with lettuce and salad greens was found in the walk-in refrigerator. The leaves were soggy, mushy and brownish indicating they were spoiled.</li> <li>[DATE] at 8:51 a.m.: A zip lock bag with chopped onions inside was found in the facility walk-in refrigerator. It had a label that indicated, [DATE] It did not indicate if this was the prepared date or used by date.</li> <li>[DATE] at 8:52 a.m. The floor of the walk-in refrigerator underneath the racks where food was stored, appeared dirty as if it had not been cleaned in weeks. Trash and water were observed on the floor. Photographs were taken.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>8. [DATE] at 8:53 a.m.: In the walk-in refrigerator, a plastic container with chopped ham was found with a prepared date of ,d+[DATE], and used-by date of ,d+[DATE]. This ham was already expired based on this. Dietary Aid U confirmed the finding and stated it should have been discarded.</p> <p>9. [DATE] at 8:55 a.m.: The freezer of the facility was completely crammed with boxes upon boxes of food items. There was no room for air circulation. Everything was extremely disorganized.</p> <p>10. [DATE] at 8:56 a.m. In the dry storage of the facility an onion was found with areas covered in black mold, deformed and mushy. This onion was stored with other onions in good condition. This was confirmed by Dietary Aid U.</p> <p>11. [DATE] at 8:59 a.m.: The metal container where dietary aids kept kitchen utensils that were clean and ready to use, had food particles and trash inside.</p> <p>12. [DATE] at 9:00 a.m.: The food preparation table next to the dishwashing machine in the back of the kitchen had walls that were covered with stains, as if nobody was cleaning this area. In addition, the knife storage rack where clean knives were stored was dirty and dusty.</p> <p>13. [DATE] at 9:,d+[DATE]:02 a.m.: The large plastic containers that stored cereal and flour, had lids and exterior surfaces that were covered with stains, and grime. The Dietary Manager, who arrived at that moment, stated the facility was planning to get new containers.</p> <p>14. [DATE] at 9:03 a.m.: The exterior of the ice machine was extremely dirty. There were whitish stains that stood out from the black surface of the plastic. A wet white napkin was used to test to see if the surface was dirty. The napkin became brown/black when physically exposed to the surface of this appliance. The Dietary Manager confirmed it was soiled. He stated the Maintenance Director was the one responsible for keeping this appliance clean.</p> <p>15. [DATE] at 9:06 a.m.: In the kitchen, right next to the door that opened towards the hallway of the facility, was a mosquito trap with several dead mosquitoes stuck to it.</p> <p>During a second observation and interview on [DATE] at 8:50 a.m., with the Dietary Manager, the food thermometer calibration log was incomplete for the month of May, 2024. The Dietary Manager stated there was no food thermometer calibration log for June of 2024. The Dietary Manager stated they were supposed to calibrate the thermometers daily in the morning and clean them twice a day, but stated there was no documentation of it. The Dietary Manager was asked to show the Surveyor where they kept emergency food. The room in which emergency food was stored, was so crammed with boxes that it made it impossible to evaluate the food. There were boxes upon boxes of items, along with old kitchen supplies, that did not allow access to the emergency food. This room was not organized until Friday, [DATE], despite having notified the Dietary Manager of the Surveyor's intention to review the emergency food as soon as possible.</p> <p>Record review of the facility policy titled, KITCHEN SANITATION, last revised on ,d+[DATE], indicated, The FNS (Facility Nutrition Services) Director is responsible for establishing a cleaning schedule. All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the facility policy titled, LABELING AND DATING OF FOODS, dated 2023, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines within this section .All prepared foods need to be covered, labeled and dated.</p> <p>Record review of the facility policy titled, GENERAL CLEANING OF FOOD &amp; NUTRITION SERVICES DEPARTMENT, dated 2023, indicated, Floors, floor mats, and walls must be scheduled for routine cleaning and maintained in good condition.</p> <p>Record review of the facility policy titled, REFRIGERATOR AND FREEZER, dated 2023, indicated, Refrigerator and freezer should be on a weekly cleaning schedule .Wipe up spills immediately.</p>

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>35842</p> <p>Based on observation, interview, and record review, the facility's Administrator failed to ensure effective oversight and necessary resources to ensure the residents' quality of care, safety, dignity, and dietary services, which include maintenance of the resident's nutrition and hydration were met to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all 81 residents when:</p> <ol style="list-style-type: none"> <li>1. The Quality Assurance and Performance Improvement Committee, whose members included the Administrator did not make sure an action plan was implemented to reduce the number of falls in the facility and promote a resident safety plan by monitoring trends and implementing changes through careful analysis of the falls, which led to 134 falls from January 2024 through May 2024. Three of these falls had resulted in major injuries, Resident 15, Resident 28, and Resident 233 (Cross-Reference to F689 - Substandard Care).</li> <li>2. The Administrator did not ensure the RD (Registered Dietician) was making frequent scheduled visits to oversee the day-to-day operations of the kitchen, which led to multiple issues in the kitchen including errors in plating prescribed diets and lack of dietary staff competencies in the cool down process, thawing process and three sink washing process. Failure to ensure adequate oversight may result in compromising the nutritional status of all residents and cross contamination of resident food and foodborne illness (Cross-Reference F800, F801, F804, &amp; F812).</li> <li>3. The Administrator did not ensure the RD made routine visits to residents with significant weight loss or gain in order to observe/interview residents to find out why they were having severe nutritional changes, and make sure new admission's nutritional assessments were done in person to minimize nutritional complications. This resulted in multiple residents, including Resident 12, Resident 20, Resident 25, Resident 29, and Resident 227, having various nutritional complications leading to further compromising the resident's medical state (Cross-Reference 692 - Substandard Care).</li> <li>4. The Administrator did not ensure there were staff in sufficient numbers to meet the individual care needs of residents resulting in residents having to wait long periods for call lights to be answered and lack of ADLs (Activities of Daily Living: are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and assisted with eating or needing to be fed), which led to a resident being left in a soiled brief for a long period causing breakdown in the resident's skin, lack of dignity for multiple residents, and had the potential for residents to become dehydrated and weight loss to occur because of not being offered water and assistance during meals or with snacks, feeling unkept and unclear, loss of self-worth and feeling of low self-esteem, which could further impacting residents' physical and psychosocial wellbeing. Residents impacted included Resident 2, Resident 3, Resident 4, Resident 6, Resident 12, Resident 14, Resident 20, Resident 21, Resident 25, Resident 29, Resident 35, Resident 40, Resident 46, Resident 50, Resident 55, Resident 58, Resident 65, Resident 67, Resident 68, and Resident 232, but not limited to (Cross-Reference F550, F677, and F725).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5. The Administrator did not ensure charting for fluid and meal intake was being documented consistently, which had the potential for residents to become dehydrated and nutritional concerns causing one's health to be compromised, which could lead to residents being hospitalized and even death, which included Resident 25, Resident 29, and Resident 227 (Cross Reference F692 and F842).</p> <p>39621</p> <p>Findings:</p> <p>Multiple observations, interviews and record reviews (Reference Federal Tags F550, F674, F584, F641, F656, F657, F658, F677, F687, F695, F710, F725, F761, F791, F800, F801, F804, F812, F835, F842, F865, F867, F868, F880 and Substandard Quality of Care Federal Tags F689 &amp; F692) during the recertification survey conducted from 6/10/24 at 8:45 a.m. to 6/24/24 at 4:48 p.m., demonstrated the facility's actions, inactions and decisions, contributed to a facility in which residents were seriously harmed (F689 &amp; F692), residents were not treated with dignity and respect (F550 and F584), residents did not receive the care and services they needed (F677, F687, F791 &amp; F725), meals were not palatable, stored or prepared in a sanitary manner (F800, F804 &amp; F812), medications were not stored properly (F761) and resident care plans were not created or revised (F657 &amp; F658). In addition, despite inadequate staffing levels, they continued to accept new residents (F725 &amp; F550).</p> <p>During an interview with the Director of Nursing (DON) on 06/21/24 at 5:01 p.m., the QAPI (Quality Assurance and Performance Improvement) program was presented and discussed. The DON stated there had been 28 resident falls in January 2024, 34 falls in February 2024, 35 falls in March 2024, 12 falls in April 2024 and 25 falls in May 2024 for a total of 134 falls for the first five months of the year. Three of these falls had resulted in major injuries. The DON stated that although the number of falls were being tracked, interventions for fall prevention measures were not being tracked. The DON stated Department Heads had not had a meeting to discuss falls specifically and decide what they were going to do to reduce the incidences of falls. The fall QAPI project presented to the Surveyors through the DON's computer had several areas that were blank or empty. The DON stated that although she was the person coordinating the QAPI plan, the Administrator was present during the meetings, therefore, she was aware of the recurrent falls.</p> <p>During this interview with the DON on 6/21/24 at 5:01 p.m., she was asked if they had a QAPI project regarding weight loss issues for the residents. The DON stated the Assistant Director of Nursing was responsible for tracking information regarding this issue but had not provided her with any information to enter into the QAPI plan. The DON presented the plan on her computer which was blank, as no data had been entered. The DON stated the Administrator was aware of the weight loss issues among the resident population of the facility. The DON stated no decisions had been made as to what they were going to measure regarding weight loss issues, in the QAPI plan. The DON was also asked if they were tracking staffing issues in the QAPI plan. The DON stated staffing was not being tracked. The DON stated that although she was the person coordinating the QAPI program, she was not being assisted by the Department Heads who were supposed to provide her with their reports.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview with Anonymous Witness O on 6/13/21 at 4:15 p.m., she stated staff at the facility were constantly being threatened by the Administration to not provide any information to family members or staff from the Department of Public Health about the care or lack of care the residents were provided, and in fact, staff had been terminated from the facility for speaking up about the unfair treatment residents were receiving. Anonymous Witness O stated incidents of abuse involving residents were not being reported to the required authorities, and staffing was so bad there were times when Certified Nursing Assistants were assigned up to 20 residents per shift. Anonymous Witness O also stated staff would get in trouble for entering the Administrator's office if not called by her, and if they discussed resident care concerns with the Administrator, she would look at them, deflect the situation, and made the staff member bringing up the concern, responsible for the issue being brought up.</p> <p>During an interview with Anonymous Witness J on 6/14/24 at 4:15 p.m., he/she stated certified nursing assistants were assigned 16 to 20 residents per shift, which did not provide them enough time to provide all needed services and supervise residents at risk for falls. Anonymous Witness J also stated that even if the facility had enough certified nursing assistants to work as a one to one (One staff working with only one resident) with a resident at risk for falls, the Administrator would send them home, and only once, in his/her employment at the facility, had he/she observed a one to one, and it was because the resident was extremely aggressive. Anonymous Witness J also stated staff were threatened by Administration against speaking to the Surveyors during this survey, and were told the Surveyors would, twist their words and take their CNA certificates away. They were also forbidden from entering the conference room where Surveyors were working without an Administrator present.</p> <p>The facility job description titled, Administrator, undated, indicated: Principal Responsibilities: . *Ensures Center compliance with all Federal, State and company regulations and policies. * Ensures that all practices and policies are carried out in the highest ethical manner. *Ensures that all Standard of Care and service provided is of the highest quality . Qualifications: . *Possess effective communication skills to maintain positive relationship with residents, families, staff, physicians, consultants, providers, and governmental agencies, their representatives, and the community at large. *Ability to implement facility and company philosophy of care. *Current knowledge of local, state and federal guidelines and regulations .</p>		

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NAME OF PROVIDER OR SUPPLIER  Crescent City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1280 Marshall Street Crescent City, CA 95531	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35842</p> <p>39621</p> <p>Based on observation, interview and record review, the facility failed to ensure medical documentation was complete and accurate for 2 of 2 sampled residents (Resident 25 and Resident 29) when:</p> <ol style="list-style-type: none"> <li>1. Resident 25, who had a significant weight loss of more than 20% in 6 months, did not have complete documentation of her meal consumption for the month of May, 2024.</li> <li>2. Resident 29, who had severe weight loss of 15.86% in six months, meal intake was not being monitored closely from 3/19/24 -6/19/24.</li> </ol> <p>These findings had the potential to result in insufficient information for the interdisciplinary team to track the care being provided to the residents, and the ability of the residents to meet their healthcare goals which could have resulted in low quality of care and harm to the residents involved.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Record review indicated Resident 25 was admitted to the facility on [DATE] with medical diagnoses including Dementia (Memory loss) and Heart Failure (Inability for the heart to pump enough blood to meet the body's needs) according to the facility Face Sheet.</li> </ol> <p>During a dining observation on 6/10/24 at 1:03 p.m., Resident 25 had just finished eating, and was observed leaving the social dining room. Resident 25 had consumed approximately 10% of her lunch meal. Resident 25 appeared extremely thin and frail, with merely skin covering her bones.</p> <p>Record review of a facility document titled, Weights and Vitals Summary, indicated Resident 25's weights were the following:</p> <p>12/05/23: 110.1 lbs.</p> <p>1/04/24: 100.6 lbs. (Weight loss of 8.6%)</p> <p>2/06/24: 100 lbs.</p> <p>3/04/24: 92 lbs. (Weight loss of 8% in 28 days, 16.43 % weight loss since 12/05/23)</p> <p>4/08/24: 91.3 lbs.</p> <p>5/06/24: 88.9 lbs. (Weight loss of 11.6 % in 4 months, since 1/04/24)</p> <p>6/11/24: 87.5 lbs. (Weight loss of 20.5 % in 6 months, since 12/05/23)</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 25's percentage of meals consumed from 5/01/24 to 6/20/24 indicated that on several days, the consumption of only one meal was recorded. For example, on 6/10/24, the only meal recorded was at 9:45 p.m., and indicated Resident 25 consumed 76 % to 100% of her meal. According to this report, on the following days, only one meal consumption was recorded per day, in the month of May 2024:</p> <p>5/02/24 at 6:00 p.m. Resident 25 refused this meal. Unknown if she ate breakfast or lunch.</p> <p>5/03/24 at 6:00 p.m.</p> <p>5/04/24 at 7:16 p.m.</p> <p>5/06/24 at 10:03 a.m.</p> <p>5/07/24 at 6:00 p.m.</p> <p>5/11/24 at 6:00 p.m.</p> <p>5/12/24 at 6:32 p.m.</p> <p>No meal consumption recorded on 5/14/24.</p> <p>5/16/24 at 9:58 p.m.</p> <p>5/18/24 at 6:00 p.m.</p> <p>5/19/24 at 4:23 p.m.</p> <p>5/20/24 at 6:00 p.m.</p> <p>5/21/24 at 6:38 p.m.</p> <p>5/23/24 at 7:46 p.m.</p> <p>5/25/24 at 6:00 p.m.</p> <p>5/26/24 at 6:11 p.m.</p> <p>5/29/24 at 7:10 p.m.</p> <p>5/30/24 at 12:55 p.m.</p> <p>Based on record review of this report, on only 12 days out of 31 (May, 2024), staff recorded more than one meal consumption for Resident 25, out of three possible, (breakfast, lunch and dinner), per day (24-hour period).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review with the Dietary Manager on 6/20/24 at 4:30 p.m., he confirmed the documentation for Resident 25's meal consumption in May 2025 was incomplete. The Dietary Manager stated being aware documentation was an issue, and stated it was the level of care staff's responsibility to document the percentage of meals consumed by the residents.</p> <p>2. A review of Resident 29's Administration Record, indicated Resident 29 was admitted [DATE], with a diagnosis of sequelae of cerebral infarction (stroke caused by disruption of blood flow to the brain), convulsions (involuntary contracture of the muscles), feeding difficulties, muscle weakness, blindness right and left eye, dementia (more confused and forgetful), psychotic disturbances (confused thinking, delusions - false beliefs that are not shared by others, hallucinations - hearing, seeing, smelling or tasting something that isn't there, changed behaviors and feelings), anxiety, major depression, and hemiplegia (paralysis of one side of the body), amongst others and Resident 29's Primary language was Spanish.</p> <p>A review of Resident 29's Quarterly MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 2/12/24, indicated Resident 29 could not complete a BIMS (Brief Interview of Mental Status), had a memory problem and cognitive skills for daily decision making was severely impaired, one upper extremity and both lower extremities had functional limitation of range of motion, Resident 29 needed supervision or touching assistance with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or once the meal is placed before the resident), and Section K - Swallowing/Nutritional Status, indicated Resident 29 had weight loss of 5% or more in the past month or loss of 10 % or more in the last six month, and Resident 29 was not on a physician-prescribed weight loss regimen.</p> <p>A review of Resident 29's Weights and Vitals Summary, indicated Resident 29 had weighed 141.9 pounds (lbs.) on 11/9/23 and on 5/13/24 (six months later), Resident 29's weight was 119.4 lbs., indicating a 15.86 % weight loss, which meant severe weight loss. Resident 29's weight on 3/4/24 was 130 lbs. and on 6/3/24 (three months later), Resident 29's weight was 115.1 lbs. indicating a 11.46 % weight loss, which meant severe weight loss.</p> <p>A review of Resident 29's Weights documented from 11/9/23 through 6/3/24, indicated the following:</p> <p>11/9/2023: 141.9 lbs.</p> <p>12/5/2023: 142.5 lbs.</p> <p>1/4/2024: 139.6 lbs.</p> <p>2/6/24: 130 lbs.</p> <p>2/8/24: 127.1 lbs.</p> <p>2/12/24: 126.4 lbs.</p> <p>2/20/24: 131.1lbs.</p> <p>2/26/24: 131.7 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/4/2024: 130.0 lbs.</p> <p>3/1/2024: 131.7 lbs.</p> <p>3/11/2024: 129.5 lbs.</p> <p>3/19/2024: 130.4 lbs.</p> <p>4/8/2024: 121.5 lbs.</p> <p>4/15/2024: 122.3 lbs.</p> <p>4/22/2024: 118.4 lbs.</p> <p>4/29/2024: 120.6 lbs.</p> <p>5/6/2024: 120.5 lbs.</p> <p>5/13/2024: 119.4 lbs.</p> <p>5/22/2024: 113.5 lbs.</p> <p>5/28/2024: 114.0 lb.</p> <p>6/3/2024: 115.1 lbs.</p> <p>A review of Resident 29's Meal Intake, task in Resident 29's electronic medical record, dated 3/19/24 -6/19/24, was not being monitored closely.</p> <p>No documentation of Resident 29's percentage of breakfast intake as follows: 3/23/24, 3/25/24, 3/28/24, 3/30/24, 4/1/24, 4/2/24, 4/5/24, 4/6/24, 4/12/24, 4/15/24, 4/16/24, 4/17/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 5/1/24, 5/2/24, 5/5/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/12/24, 5/14/24, 5/17/24-5/27/24, 5/30/21, 6/1/24-6/5/24, 6/8/24, 6/10/24, 6/13/24-6/14/24, and 6/16/24-6/17/24,</p> <p>No documentation of Resident 29's percentage of lunch intake as follows: 3/23/24, 3/25/24, 3/28/24, 3/29/24, 3/30/24, 4/1/24, 4/2/24, 4/5/24, 4/8/24, 4/9/24, 4/11/24, 4/12/24, 4/13/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/24/24, 4/26/24, 4/27/24, 4/29/24, 5/1/24, 5/2/24, 5/5/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/11/24, 5/12/24, 5/13/2, 5/14/24, 5/16/24, 5/18/24-5/21/24, 5/23/24, 5/25/24-5-27/24, 6/1/24-6/5/24, 6/8/24, 6/10/24, 6/13/24-6/14/24, and 6/16/24-6/17/24.</p> <p>No documentation of Resident 29's percentage of dinner intake as follows: 3/21/24, 3/22/24, 3/29/24, 4/9/24, 4/11/24, 5/31/24, 6/11/24, and 6/13/24-6/14/24.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy titled, ADL (Activities of Daily Living-Activities related to personal care such as showering, eating, etc.) Documentation, last revised on July 1, 2020, indicated, The Facility will ensure documentation of the care provided to the residents . The CNA (Certified Nursing Assistant) will document the care provided on the facility's method of documentation, manually or electronic.</p> <p>The facility job description titled, CNA, undated, indicated: . General Duties and Responsibilities: General - . Assist in preparing residents for meals (taking to/ from dining room, serving trays, placing bibs, assisting in feeding or cutting food, removal of trays, supervision in dining room, etc.), Serve nourishment in accordance with established facility procedures, Feed residents who cannot feed themselves, Assure that resident's food is accessible and self-help devices are available as needed . Clinical - .Record resident's food and nourishment intake as directed.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>39621</p> <p>Based on interview and record review, the facility failed to establish, implement and maintain a QAPI/QAA program (Quality Assurance Performance Improvement/Quality Assessment and Assurance-A program that involves a systematic approach to quality assurance and performance improvement. It is designed to identify areas of improvement and develop strategies to improve the quality of care provided to the residents) that identified system-wide problems and reassessed the effectiveness of their interventions to correct quality deficiencies. The facility failed to maintain documentation of an effective, comprehensive and data driven QAPI program that involved the governing body and executive leadership when the person responsible for the QAPI program's development was the Director of Nursing (DON), and no QAPI meeting minutes and documentation were maintained and provided. This failure resulted in inability to correct deficiencies that resulted in substandard quality of care related to nutrition issues and falls with injuries (Reference Federal tags F689 and F692) experienced by several residents of the facility.</p> <p>Findings:</p> <p>During an interview with the DON on 06/21/24 at 5:01 p.m., the QAPI program was presented and discussed. The DON stated Department Heads within the facility were supposed to bring reports to her of resident concerns or issues, to enter into the QAPI system but they were not bringing the reports. The DON stated she bought a screen and a projector for this purpose, but they were inefficient, as there was insufficient participation by Department Heads. When asked about the number resident falls at the facility, the DON stated there had been 28 falls in January 2024, 34 falls in February 2024, 35 falls in March 2024, 12 falls in April 2024 and 25 falls in May 2024, for a total of 134 falls for the first five months of the year. Three of these falls resulted in major injuries. The DON stated that although the number of falls were being tracked, interventions for fall prevention measures were not being tracked. The DON stated Department Heads had not had a meeting specifically to discuss falls and decide what they were going to do to reduce the incidences of falls. The fall QAPI project presented to the Surveyors through the DON's computer had several areas that were blank or empty.</p> <p>During this interview with the DON on 6/21/24 at 5:01 p.m., she was asked if they had a QAPI project regarding weight loss issues for the residents. The DON stated the Assistant Director of Nursing was responsible for tracking information regarding this issue but had not provided her with any information to enter into the QAPI plan. She presented the plan on her computer which was blank, as no data had been entered. The DON stated the Administrator was aware of the weight loss issues among the resident population of the facility. The DON stated no decisions had been made as to what they were going to measure regarding weight loss issues, in the QAPI plan. The DON was also asked if they were tracking staffing issues in the QAPI plan. The DON stated staffing was not being tracked. The DON stated the Administrator was present in the QAPI meetings, but she (the DON) was the one coordinating the QAPI program, however, she was not being assisted by the Department Heads who were supposed to provide her with their reports, and she believed some Department Heads were not tracking any data.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy titled, QAPI Policy &amp; Procedure, dated 2022, indicated, Use this Plan-Do-Study-Act (PDSA) to plan and document your progress with tests of change conducted as part of chartered performance improvement projects (PIPs). While the charter will have clearly established the goals, scope, timing, milestones, and team roles and responsibilities for a project, the PIP team asked to carry out the project will need to determine how to complete the work. This tool should be completed by the project leader/manager/coordinator with review and input by the project team.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>35842</p> <p>Based on interview and record review, the facility failed to implement an effective facility wide Quality Assurance Performance Improvement (QAPI) program that included the required members for the QAPI meeting, responsible for identifying significant resident safety and care issues, and failed to ensure that performance improvement activities fully evaluated the depth and scope of the issues, developed a plan to correct identified issues, implement the plan and monitor the results of the facility plan and make changes if the plan was not effective.</p> <ol style="list-style-type: none"> <li>Lack of Infection prevention input and data to monitor Hand Hygiene for staff and residents (Cross-Reference F8800).</li> <li>Lack of monitoring of Activities of Daily Living (ADL) to ensure residents were receiving two showers a week, and the documentation appropriate and accurate (Cross-Reference F677).</li> <li>Lack of monitoring falls in 2024, Falls with injuries: the facility had one in 4/2024, one in 5/2024, and one in 6/2024. Total number of falls: 28 (January), 34 (February), 35 (March), 12 (April), and 25 (May) (Cross-Reference F689: Substandard Care &amp; F865).</li> <li>Lack of monitoring documentation of meal and fluid intake. Multiple residents with significant weight loss (Cross-Reference F692 and F842).</li> <li>Lack of monitoring to make sure residents were being treated with dignity and respect (Cross-Reference F550).</li> <li>Lack of monitoring call light response time leading to residents waiting for long periods (Cross-Reference F550).</li> <li>Lack of in person RD oversight of the kitchen and residents with nutrition/hydration issues (Cross-Reference F800, F801, F804, F812, and F692: Substandard Care).</li> </ol> <p>This failure to identify and prioritize care areas resulted in facilities' lack of identification of resident safety issues, developing a plan to correct identified issues, implementing the plan and monitoring the results. This failure had the potential for decreased quality of care, potential for harm and even death.</p> <p>Findings:</p> <p>A review of the QAPI committee sign in sheets indicated QAPI meetings took place on 2/28/23, 3/23/24, 4/27/23, 5/25/23, 7/20/23, 11/30/23, 12/21/23, 1/24/24, 2/28/24, 3/28/24, 4/18/24, and 5/23/24. The Medical Director was present on 2/28/23, 4/27/23, 7/20/23, 1/24/24, and 4/18/24. The meetings lasted one-half- hour, except on 11/30/23,12/21/23, 3/28/24, 4/18/24, and 5/23/24, the QAPI meetings lasted 15 min. The Medical Director was not present at the 11/30/2023 quarterly QAPI meeting.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's 2024-2025 Quality Assurance &amp; Performance Improvement (QAPI), indicated: . Mission: Our mission is to consistently deliver high quality, person-centered care with dignity, respect, compassion, and integrity. We strive to enrich and enhance every life we touch . QAPI Plan: . Goal 2: the facility will reduce the quality measure rate for falls with major injury 1.9 percent by 12/31/24 . Goal 4: The facility will decrease the number of falls by 50 percent. Goal 5: Call lights will be addressed within five minutes or less by 12/31/2024 . Goal 13: ADL documentation: showers, meals all other ADLS .</p> <p>During an interview on 6/21/24 at 12:30 p.m., the Director of Nursing (DON) stated the Fall Committee never got done. The DON stated the Administrator will not let her do her job duties as a DON. The DON stated she implemented a disciplinary action plan for all the call offs: 1. Verbal Warning, 2. Written Warning, 3. Suspension and 4. Termination. The DON stated the owner liked the frequent staff Call Off plan and asked for it to be implement at once. Fall Risk care plan should be updated right after accident. The resident should have a BM at least every 3 days.</p> <p>During a phone interview on 6/21/24 at 2:15 p.m., Physician 1 stated he came to the facility monthly and attended the QAPI meetings. Physician 1 stated falls were reviewed and weight issues were monitored. Physician 1 stated the (Registered Dietician) RD made the recommendations which Physician 1 approved and Physician 1 would order medications to improve the resident's appetite such as Remeron (treats depression and causes weight gain). Physician 1 stated the resident population in the community was challenging and staffing was a challenge. Physician 1 felt the resident's needs were being addressed. Physician 1 was asked severely times about what has the QAPI Committee implemented to promote fall prevention in order to keep the residents safe and what was the Weight Variance Committee bring to QAPI Committee to decrease the percentage of nutritional issues such as severe weight loss and gain. Physician 1 felt the residents' needs were being addressed and he felt the staff were doing a good job regarding weight loss. Physician 1 felt surveyors were not looking at the big picture when discussing weight loss/gain and falls. Physician 1 stated, You are not looking at the Forest through the Trees.</p> <p>During an interview with the DON on 06/21/24 at 5:01 p.m., the QAPI program was presented and discussed. The DON stated Department Heads within the facility were supposed to bring reports to her of resident concerns or issues, to enter into the QAPI system but they were not bringing the reports. The DON stated she bought a screen and a projector for this purpose, but they were inefficient, as there was insufficient participation by Department Heads. When asked about the number resident falls at the facility, the DON stated there had been 28 falls in January 2024, 34 falls in February 2024, 35 falls in March 2024, 12 falls in April 2024 and 25 falls in May 2024, for a total of 134 falls for the first five months of the year. Three of these falls resulted in major injuries. The DON stated that although the number of falls were being tracked, interventions for fall prevention measures were not being tracked. The DON stated Department Heads had not had a meeting specifically to discuss falls and decide what they were going to do to reduce the incidences of falls. The fall QAPI project presented to the Surveyors through the DON's computer had several areas that were blank or empty.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Crescent City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1280 Marshall Street Crescent City, CA 95531	
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During this interview with the DON on 6/21/24 at 5:01 p.m., she was asked if they had a QAPI project regarding weight loss issues for the residents. The DON stated the Assistant Director of Nursing was responsible for tracking information regarding this issue but had not provided her with any information to enter into the QAPI plan. She presented the plan on her computer which was blank, as no data had been entered. The DON stated the Administrator was aware of the weight loss issues among the resident population of the facility. The DON stated no decisions had been made as to what they were going to measure regarding weight loss issues, in the QAPI plan. The DON was also asked if they were tracking staffing issues in the QAPI plan. The DON stated staffing was not being tracked. The DON stated the Administrator was present in the QAPI meetings, but she (the DON) was the one coordinating the QAPI program, however, she was not being assisted by the Department Heads who were supposed to provide her with their reports, and she believed some Department Heads were not tracking any data.</p> <p>During a phone interview on 6/24/24 at 1:46 p.m., Physician 1 stated he felt as if he had been attending QAPI quarterly. Physician 1 stated falls were a big issue that should be trended to see why the resident was falling, what time of day, interventions updated, etc. Physician 1 stated how QAPI was monitoring/tracking falls and implementing safeguards to decrease the number of falls occurring in the facility would be something to address with the Administrator. Physician 1 stated he was sympathetic regarding some of these residents falling frequently because no matter what interventions you put in place the residents will still tend to fall. It was addressed to Physician 1, if a facility decided to admit a resident, was it not up to the facility to make sure the resident was safe and for a facility to have over 50 falls in a two-month period. The data on falls was not being analyzed for trends/similarities so there was a comprehensive data on why so many falls occurred in order to prevent falls and falls with injuries. Physician 1 stated, I agree. Physician 1 stated again, something to take up with the Administrator.</p> <p>The facility policy and procedure titled, QAPI Policy &amp; Procedure, dated 2022, indicated, Use this Plan-Do-Study-Act (PDSA) to plan and document your progress with tests of change conducted as part of chartered performance improvement projects (PIPs) . Remember that a PIP will usually involve multiple PDSA cycles in order to achieve your aim. Use as many forms as you need to track your PDSA cycles. Identify opportunities for improvement that exist (look for causes of problems that have occurred -see Guidance for Performing Root Cause Analysis with Performance Improvement Projects; or identify potential problems before they occur . Points where breakdowns occur . Identify better ways to do things that address the root causes of the problem .</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>35842</p> <p>Based on interview and administrative document review, the facility failed to ensure it had an effective Quality Assurance Performance Improvement (QAPI) program when the Medical Director or designee did not consistently attend meetings. This failure to have required committee members consistently attend meetings had the potential to result in lack of facility identification of significant resident safety issues, developing a plan to correct identified issues, implementing the plan, and monitoring the results which had the potential to affect the outcomes, dignity, and safety of facility residents.</p> <p>Findings:</p> <p>A review of the QAPI committee sign in sheets indicated QAPI meetings took place on 2/28/23, 3/23/24, 4/27/23, 5/25/23, 7/20/23, 11/30/23, 12/21/23, 1/24/24, 2/28/24, 3/28/24, 4/18/24, and 5/23/24. The Medical Director was present on 2/28/23, 4/27/23, 7/20/23, 1/24/24, and 4/18/24. The meetings lasted one-half hour, except on 11/30/23, 12/21/23, 3/28/24, 4/18/24, and 5/23/24, the QAPI meetings lasted 15 min. The Medical Director was not present at the 11/30/2023 quarterly QAPI meeting.</p> <p>During an interview on 6/21/24 at 3:34 p.m., it was addressed to the Administrator per reviewing the QAPI sign in sheets, the Medical Director missed the 11/30/23, quarterly QAPI meeting. The last meeting the Medical Director attended was 7/20/23 and he did not attend another QAPI meeting until 1/24/24, which was six months later. The Administrator stated the Medical Director could have missed the QAPI meeting because of the weather preventing him from coming in.</p> <p>The facility QAPI, dated 2024-2025, indicated: . Guiding principle #3: In our organization QAPI includes all employees all departments and all services .</p> <p>The job description titled, Medical Director, revision 6/2012, indicated: . Agreement: 1. Duties and Obligations of Medical Director: . 1.5 Compliance with Facility's Policies and with Laws. Physician shall comply with and shall perform the Services in accordance with: (i) Facility's policies and procedures, including the Facility's Compliance Plan and Code of Conduct, (ii) all applicable local, state and federal laws and regulations; .</p> <p>?</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>27532</p> <p>Based on observation, interview and record review, the facility failed to ensure staff practiced hand hygiene and encouraged resident to wash or wipe their hands with wet washcloths before and after meals when:</p> <ol style="list-style-type: none"> <li>Five residents (Resident 13, Resident 64, Resident 3, Resident 9, and Resident 63) were served their lunch trays without washing or wiping their hands clean before eating.</li> <li>None of the residents in the social dining room were observed being reminded about hand sanitation prior to their meals, or provided hand sanitation supplies.</li> <li>Staff used the same gloves while feeding three residents at the same time and staff helped various residents with their meals without hand sanitizing in between.</li> </ol> <p>This failure can result in the spread of infection or an outbreak among the already frail health of the residents and staff in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During an observation on 6/10/24, at 12:43 PM, a CNA was observed serving lunch to Resident 13 in his room. The CNA was not heard or observed to offer to wipe with a washcloth or wash the hands of Resident 13.</li> </ol> <p>During an interview on 6/10/24, at 1:00 PM, Unlicensed Staff W stated they usually clean their residents in the morning and the independent residents usually wash their hands. They usually do not offer to wash or wipe with wash cloths the hands of the residents before meals.</p> <p>During a concurrent observation and interview on 6/10/24, at 01:01 PM, a CNA was not heart to offer to wash or wipe the hands of Resident 64 before serving his lunch tray. Resident 64 stated he was not asked to wash or wipe his hand with a washcloth before lunch.</p> <p>During a concurrent observation and interview on 6/10/24, at 1:07 PM, A CNA served Resident 3 her lunch tray. The CNA did not offer to wash or wipe Resident 3's hands before giving her lunch tray. Resident 3 and her roommate Resident 65 stated CNAs never offer to wash resident's hands.</p> <p>During an interview on 6/12/24, at 12:57 PM, when asked if the CNA who served her lunch tray offered to wash or wipe her hands before eating, Resident 9 stated, no.</p> <p>During an observation 06/12/24 12:58 PM, Resident 13 was again not offered to wash or wipe his hands before his meal.</p> <p>During an interview on 6/12/24, at 12:59 PM, Unlicensed Staff X stated, she thought the other CNAs already offered sanitizing wipes before trays were offered. She did not offer anymore.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/12/24, at 01:01 PM, Unlicensed Staff Y stated she had not offered to wash or wipe Resident 3's hands before her meal because she thought the CNA assigned to the hall already did it.</p> <p>During an interview on 6/12/24, at 1:02 PM, Unlicensed Staff D stated he was assigned to the North Hall but had not offered the sanitizing wipe to wipe the residents' hands before the trays were served because he was busy. Unlicensed Staff D confirmed he had not offered to wash or wipe Resident 13's hands before his meal.</p> <p>During a concurrent observation and interview on 6/12/24, at 1:05 PM, Unlicensed Staff Z, served Resident 63's lunch without officering to wash or wipe his hands with a washcloth. Unlicensed Staff Z stated he thought the CNA assigned to the hall already distributed the washcloths. Unlicensed Staff Z stated he had cleaned the hands of his residents especially those who needed help at his assigned hall before the trays were served.</p> <p>39621</p> <p>2. During a dining observation on 6/10/24 at 12:14 p.m., in the social dining room of the facility, the entire dining process was observed for lunch, from the time the residents were sitting in their tables, prior to being served their meals, to the time the meals were picked up by staff. At no point during the observation, were residents offered hand sanitizer or hand washing services. Their lunch meals on that day included a piece of bread that residents would touch with their bare hands. One of the staff members assisting residents with lunch in the social dining room was the Director of Staff Development (DSD).</p> <p>During an interview in the social dining room of the facility on 6/10/24 at 1:11 p.m., Resident 61 and Resident 21 stated not having received reminders to wash their hands or offered hand sanitizer prior to having their lunch meal.</p> <p>During an interview on 6/10/24 at 1:22 p.m., the DSD was asked if resident had received hand sanitation services prior to being served their lunch meals during the dining observation on 6/10/24. The DSD stated she did not sanitize the residents' hands prior to being served their lunch meals.</p> <p>During an interview with Resident 14 on 6/14/24 at 11:30 a.m., she stated facility staff had begun to provide them with hand sanitizer before meals after 6/10/24 (the day residents were observed not being offered hand sanitation services during lunch time), but during the weekend of 6/15/24 through 6/16/24, when the Surveyors were not in the facility, staff again did not offer hand sanitizer to the residents. According to Resident 14, hand sanitizer was offered to the residents prior to their meals only when the Surveyors were present.</p> <p>35842</p> <p>3. During a Total Assisted Dining (TAD) Room observation, on 6/10/24 at 12:18 p.m., there were eight residents and three staff members (Unlicensed Staff C, Unlicensed Staff E and a nurse) assisting the residents. Unlicensed Staff E was wearing gloves while he was feeding Resident 4 to his left and Resident 2 to his right.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 227 had arrived at the TAD Room and room was made for her to sit at the table next to Resident 2. Unlicensed Staff E, who was wearing gloves while feeding the resident on his left and the resident on his right, stopped feeding the two residents and went to help Resident 227 cut her meat while wearing the same gloves. Unlicensed Staff E went back to feeding Resident 4 and Resident 2 without changing his gloves.</p> <p>Unlicensed Staff E got up from feeding Resident 4 and Resident 2 to give Resident 227 a bag of Cheetos. Unlicensed Staff E opened up Resident 227's Cheetos using the same gloves. Unlicensed Staff E used the same gloves while assisting and feeding Resident 4, Resident 2, and Resident 227.</p> <p>Unlicensed Staff C was feeding Resident 52. After Licensed Staff C was done feeding Resident 52, Unlicensed Staff C started feeding Resident 55. Unlicensed Staff C did not sanitize her hands in between feeding the two residents.</p> <p>Unlicensed Staff E was trying to wake up Resident 2 and touched her fork to give her a bite of meat using the same gloves he was feeding Resident 4 with and assisting Resident 227. Unlicensed Staff E then assisted Resident 2 with her orange juice: held Resident 2's orange juice and her straw and placed the straw in her mouth. Unlicensed Staff E then started to feed Resident 4 ice cream. Unlicensed Staff E then held the left arm of Resident 4's wheelchair to direct her back to the table. Unlicensed Staff E never changed his gloves throughout the meal.</p> <p>Unlicensed Staff C picked up a few of the meal trays on table and placed them in the meal cart. Unlicensed Staff C then went back to feeding Resident 55 without sanitizing her hands. Unlicensed Staff C picked up two juices on the table and gave one of the juices to the nurse feeding a resident and gave the other juice to Resident 55. Unlicensed Staff C had not sanitized her hands in between assisting/feeding residents.</p> <p>During TAD Room observation on 6/12/24 at 12:26 p.m., a nurse and Unlicensed Staff C passed out the resident meal trays and set-up residents for lunch, but no hand hygiene was offered prior to the residents' lunch. Prior to lunch, Resident 29 had been playing with a balloon other residents and staff had been touching but no hand hygiene was offered prior to her lunch. Resident 29 was blind, and her primary language was Spanish. Resident 29 was set-up for lunch but no staff member in the TAD Room spoke Spanish nor did any staff member assist Resident 29 on placement of where her food was on her plate and tray, so Resident 29 ate her pasta with her uncleaned fingers. Resident 29 was not offered hand hygiene after eating her pasta with her fingers.</p> <p>During an interview on 6/12/24 at 12:37 p.m., Unlicensed Staff C was asked if the residents in the TAD Room received hand hygiene before their lunch. Unlicensed Staff C state, Good question. None of the residents in the TAD Room were offered hand hygiene before lunch.</p> <p>During an interview on 6/12/24 at 1:10 p.m., Unlicensed Staff D was asked if residents were offered a washcloth to wash their hands and face before meals. Unlicensed Staff D said, You mean to offer each resident a washcloth before each meal? When responded to in the affirmative, Unlicensed Staff D said, That did not happen, offering each resident a washcloth to wash their face and hands before each meal.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/24 at 2:30 p.m., Unlicensed Staff C stated the HCP (Health Care Personal) were not trained to assist or give each resident a washcloth before and after each meal to wash their hands and face. Unlicensed Staff C stated if an HCP were feeding multiple residents at the same time with the same gloves that could cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). Unlicensed Staff C stated hand sanitizing one's hands in between assisting residents in the TAD Room was missed because the hand sanitizer dispenser was on the wall in the hallway right of the door. There was no hand sanitizer dispenser inside the TAD Room.</p> <p>During an interview on 6/14/24 at 11:15 a.m., the Infection Preventionist (IP) stated a Certified Nursing Assistant (CNA) should not be feeding three residents in the TAD Room with the same gloves. The CNA should use a new pair of gloves to feed each resident and hand sanitize after removing the old pair of gloves and before applying the new pair of gloves to prevent cross contamination. The IP stated each resident should be offered hand washing before each meal. The IP stated there were anti-bacteria wipes and hand sanitizer to offer the residents who were in the dining rooms. The IP stated it was difficult to keep the dining rooms sanitized when giving residents warm wash cloths so anti-bacteria wipes were offered instead.</p> <p>A review of the facility's policy titled, Hand Hygiene, last revised on 12/31/21, indicated, the facility considers hand hygiene the primary means to prevent the spread of infection. Facility staff follow the hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors. Facility staff, visitors, and volunteers must perform hand hygiene procedures before eating. The policy did not specify for staff to offer or help residents wash or wipe their hands before and after eating.</p>		