

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Jerold Phelps Comm Hosp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 733 Cedar Street Garberville, CA 95542	

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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41283</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident 1) of three sampled residents was treated with respect and dignity when Certified Nursing Assistant A (CNA A) shaved Resident 1's pubic hair without Resident 1's consent. This failure had the potential to cause risks like cuts, infections, and skin irritations to Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Minimum Data Set (MDS- is a standardized assessment tool that measures health status in nursing home residents) dated 1/26/25, indicated Resident 1:</p> <ul style="list-style-type: none"> -had a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 5 which indicated he had severe cognitive (the mental process involved in knowing, learning, and understanding things) impairment; - was dependent on staff for toileting hygiene; - has dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), anxiety (a group of mental health conditions characterized by excessive worry, fear, and avoidance behaviors that significantly interfere with daily life), and depression (a mood disorder characterized by persistent sadness and loss of interest or pleasure in daily activities). <p>During an interview on 4/17/25 at 11:25 a.m., Licensed Nurse B (LN B) stated she observed Resident 1's pubic area was shaved sloppily (in a careless, untidy, or messy way). LN B stated she submitted a report regarding the incident on 4/3/25. LN B stated she also reported her observation to the Director of Nursing (DON) on 4/4/25.</p> <p>During an interview on 4/17/25 at 12:15 p.m., LN C stated she reported what happened to Resident 1 to the DON on 4/4/25. The LN C stated she had been questioned by Human Resources (HR) about Resident 1. The LN C notified HR Resident 1 was unable to give consent to whomever shaved him, and there was no reason for him to be shaved because he was not scheduled to have surgery. The LN C stated she felt Resident 1 had been abused.</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 - Few</p>	<p>During an interview on 4/19/25 at 2 p.m., CNA D stated on 3/29/25, she witnessed CNA A shave Resident 1's pubic hair using Resident 1's personal beard shaver. The CNA D stated she and CNA A both worked the 7 a.m. to 7:30 p.m. shift on 3/29/25. The CNA D stated she was confused as to why CNA A shaved Resident 1's pubic hair because Resident 1 had not asked for it and CNA A had not given a reason why she did it. The CNA D stated Resident 1 looked agitated but had not asked CNA A to stop. The CNA D stated on 4/3/25 at around 5 p.m., she received a phone call from CNA A asking her not to tell anybody she had shaved Resident 1's pubic area. The CNA D stated she reported for work on 4/5/25 and informed LN C what CNA A did to Resident 1.</p> <p>During an interview on 4/20/25 at 10:30 a.m., CNA A confirmed she worked with CNA D to provide incontinent care to Resident 1 on 3/29/25. CNA A stated she observed Resident 1 was hurting as she cleaned him from front to back because he had long pubic hair. The CNA A acknowledged she used Resident 1's own personal shaving equipment to shave his pubic hair. The CNA A stated Resident 1 was fine when she started shaving his pubic hair but Resident 1's body language looked like he was uncomfortable with the shaving, so she stopped right away. The CNA A stated the incident was investigated by the DON and a person from HR The CNA A stated she signed a document which indicated she understood she had committed a violation.</p> <p>During an interview on 4/21/25 at 1:07 p.m., the DON stated it was her expectation CNAs would not unilaterally act without discussing and checking with licensed nurses when providing care that is not included in a resident's plan of care.</p> <p>A review of an undated facility document titled Statement of Patient Rights indicated, Patients of this facility have the right to .Considerate and respectful care, and to be comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences .receive as much information about any proposed .procedure as you may need in order to give informed consent or to refuse a course of treatment.</p> <p>A review of a facility document titled Job Description: Certified Nursing Assistant dated 6/19/2019, indicated, The Certified Nursing Assistant (CNA) employs intellectual, interpersonal, and technical skills to perform basic resident/patient care, under the supervision of the RN (Registered Nurse) or LVN (Licensed Vocational Nurse) . Adheres to all facility policies and procedures .Assists with problem solving and resolution in collaboration with the [LVN], Resource [RN] and [DON] within the Skilled Nursing Facility.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>41283</p> <p>Based on interview and record review, the facility failed to ensure their policy regarding resident abuse indicated the person responsible for investigating abuse allegations was to submit allegations of resident abuse within 2 hours of being made aware and submit an investigation summary within 5 business days to the California Department of Public Health (CDPH). These failures decreased the facility's potential to protect a census of 8 residents from abuse and take appropriate corrective action.</p> <p>Findings:</p> <p>A review of the facility ' s policy and procedure (P&P) titled Abuse and Neglect Investigation printed on 4/17/25 was conducted on 4/28/25. Upon review, the P&P did not indicate the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH nor did it indicate a summary of the investigation was to be submitted to CDPH within 5 business days.</p> <p>On 4/28/25 at 10:13 a.m., the CDPH Surveyor requested a copy of the facility ' s P&Ps regarding reporting allegations of abuse to CDPH. The documents were received by CDPH on 4/28/25 at 3:39 p.m.</p> <p>A review of the facility ' s undated P&P titled Abuse Reporting Requirements showed no documented evidence the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH.</p> <p>In an interview on 5/6/25 at 10:54 a.m., the Director of Nursing (DON) acknowledged neither the P&Ps titled Abuse and Neglect Investigation and Abuse Reporting Requirements indicated the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH and the investigation summary was to be submitted to CDPH within 5 business days. The DON stated she was notified of the 2-hour reporting timeframe by the facility ' s Chief Quality Officer and was notified of the 5 day investigation summary timeframe from the CDPH Surveyor.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41283</p> <p>Based on interviews and record reviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. An allegation of abuse was reported to the California Department of Public Health (CDPH) within 2 hours of awareness of the allegation for one resident (Resident 1) of three sampled residents when Certified Nursing Assistant D (CNA D) and Licensed Nurse E (LN E) did not report when CNA A shaved Resident 1 ' s pubic hair without medical reason and without consent; and, 2. The facility submitted the investigation summary within 5 business days to CDPH. <p>These failures decreased the facility's potential to protect Resident 1 and other residents from abuse and take appropriate corrective action. Cross reference F607.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 1's Minimum Dats Set (MDS- is a standardized assessment tool that measures health status in nursing home residents) dated 1/26/25, indicated Resident 1: <ul style="list-style-type: none"> -had a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 5 which indicated he had severe cognitive (the mental process involved in knowing, learning, and understanding things) impairment. - was dependent on staff for toileting hygiene; - has dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), anxiety (a group of mental health conditions characterized by excessive worry, fear, and avoidance behaviors that significantly interfere with daily life), and depression (a mood disorder characterized by persistent sadness and loss of interest or pleasure in daily activities). <p>A review of a document titled Report of Suspected Dependent Adult/Elder Abuse faxed to the CDPH on 4/7/25 at 2:03 p.m., from the facility indicated, Date Completed .4/5/2025 .Received report from nursing staff that another staff member unilaterally clipped a [Resident 1's] pubic hair without consulting others. The employee [CNA A] in question was placed on administrative leave pending completion of investigation and follow up action.</p> <p>During an interview on 4/17/25 at 11:25 a.m., LN B stated she observed Resident 1's pubic area was shaved sloppily (in a careless, untidy, or messy way) on 4/3/25. The LN B confirmed she submitted an incident report regarding her observation of Resident 1's pubic area on 4/3/25 at approximately 6 p.m. to the facility's Human Resources (HR) department. LN B stated she also reported her observation to the Director of Nursing (DON) on 4/4/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/19/25 at 2 p.m., CNA D stated on 3/29/25, she witnessed CNA A shave Resident 1's pubic hair using Resident 1's personal beard shaver. The CNA D stated she and CNA A both worked the 7 a.m. to 7:30 p.m. shift on 3/29/25. CNA D stated she was confused as to why CNA A shaved Resident 1's pubic hair because Resident 1 had not asked for it and CNA A had not given a reason why she did it. CNA D stated Resident 1 looked agitated while CNA A shaved him but had not asked CNA A to stop. CNA D stated on 4/3/25 at around 5 p.m., she received a phone call from CNA A asking her not to tell anybody she had shaved Resident 1's pubic area. CNA D stated she reported for work on 4/5/25 and informed LN C what CNA A did to Resident 1.</p> <p>During an interview on 4/20/25 at 8:29 p.m., LN E stated CNA D reported to her CNA A shaved Resident 1's pubic hair on 3/29/25. LN E stated she did not know what to do so she reported this to the oncoming nurse, whose name she could not recall. LN E stated she had worked at other facilities and knew that things like shaving were care planned. LN E stated she had observed Resident 1's pubic area after the incident and noticed it was shaved at the center, but there was pubic hair on the sides, and it was not completely shaven. LN E stated the skin was a little red. LN E stated she asked CNA A why she shaved Resident 1's pubic hair and CNA A replied it was for hygiene, and did not elaborate or explain the reason further. LN E stated CNA A did not ask her if she could shave Resident 1's pubic hair.</p> <p>On 4/28/25 a review of the facility ' s policy and procedure (P&P) titled Abuse and Neglect Investigation printed on 4/17/25 was conducted. Upon review, the P&P did not indicate the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH.</p> <p>On 4/28/25 at 10:13 a.m., the CDPH Surveyor requested a copy of the facility ' s P&Ps regarding reporting allegations of abuse to CDPH. The documents were received by CDPH on 4/28/25 at 3:39 p.m.</p> <p>A review of the facility ' s undated P&P titled Abuse Reporting Requirements showed no documented evidence the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH.</p> <p>During an interview on 5/1/25, at 1:25 p.m., the DON stated facility staff were expected to report suspected abuse as required. The DON stated CNA D and LN E were mandated reporters of elder abuse and should have reported the allegation as soon as they were aware but no later than 2 hours of becoming aware of the suspicion of abuse on 3/29/25. The DON stated it was her understanding that the reporting requirements on a suspected abuse allegation was to report it immediately or not later than 2 hours.</p> <p>In an interview on 5/6/25 at 10:54 a.m., the DON acknowledged neither the P&Ps titled Abuse and Neglect Investigation and Abuse Reporting Requirements indicated the facility was to report allegations of resident abuse within 2 hours of the facility ' s awareness to CDPH. The DON stated she was notified of the 2-hour reporting timeframe by the facility ' s Chief Quality Officer.</p> <p>2. During an interview on 4/21/25, at 1:07 p.m., the DON stated she did not provide a 5-day follow-up report to CDPH.</p> <p>On 4/28/25 a review of the facility ' s policy and procedure (P&P) titled Abuse and Neglect Investigation printed on 4/17/25 was conducted. Upon review, the P&P did not indicate the facility was to submit a summary of the investigation to CDPH within 5 business days.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/6/25 at 10:54 a.m., the DON acknowledged the P&Ps titled Abuse and Neglect Investigation and Abuse Reporting Requirements did not indicate the investigation summary was to be submitted to CDPH within 5 business days. The DON stated she was notified of the 5-day investigation summary timeframe from the CDPH Surveyor.</p>