

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  03/01/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>27532</p> <p>Based on observation, interview and record review, the facility failed to ensure one of six residents (Resident 57) was informed in advance, by the physician or other practitioner or professional, of the use, the risks and benefits of a psychotropic (class of medication affecting the thoughts and behaviors of the person using the drug) and other medication options. This failure deprived Resident 57 her right to be receive information about the medication or other treatment options as basis for her decision to choose the medication or treatment she preferred.</p> <p>Findings:</p> <p>During an observation of medication administration on 2/29/24, at 9:07 AM, Licensed Nurse H (LN H) administered one (1) 5 mg (milligram = unit of measure of mass in the metric system equal to a thousandth of a gram) tablet of Diazepam (a class of medication called benzodiazepine used to relieve symptoms of anxiety and alcohol withdrawal, may also be used treat certain seizure disorders and help relax muscles or relieve muscle spasm) to Resident 57.</p> <p>During a review of records on 2/29/24, at 3:15 PM, the missing informed consent for Resident 57's Diazepam was requested from the Chief Nursing Officer (CNO)</p> <p>During a concurrent review of record and interview on 3/1/24, at 9:25 AM, the CNO provided the informed consent for diazepam, signed by Resident 57 and the physician, dated 2/29/24. The CNO acknowledged the informed consent was done on 2/29/24.</p> <p>A review of the facility policy titled: Consent for use of psychoactive medications, dated 3/30/23, indicated: the physician is responsible for obtaining informed consent .must document the informed consent in the chart. The policy also indicated: per Title 22 CCR Section 72528(c) requires facility staff to verify that the patient's health record contains such documentation prior to initiating the therapy. The policy further indicated: before initiating the administration of psychoactive drugs which may lead to the inability to regain use of normal bodily function, the ordering provider must obtain informed consent.</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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>27532</p> <p>Based on observation, interview, and record review, the facility failed to complete a smoking assessment on admission for one of six residents (Resident 57) to determine Resident 57's functional capacity to safely smoke with or without assistance and need for protective devices. This failure had the potential to result to inappropriate care and provision of supervision and protective devices and result in fire hazard to both the resident and facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/27/24, at 8:44 AM, Resident 57 was smoking outside the facility with one of the security staff. A portable ashtray was positioned by the right side of Resident 57's wheelchair. Resident 57 stated she smoked after meals, outside the facility.</p> <p>During an interview on 2/28/24, at 8:53 AM, when asked if Resident 57 was assessed for smoking, LN B stated Resident 57 was a safe smoker. When LN B was asked where the smoking assessment of Resident 57 was, he could not provide the assessment ,and he would refer to the Health Information Management (HIM)/Information technician (IT) to print out the document from the facility's electronic medical records.</p> <p>During an interview on 2/28/24, at 9:55 AM, Resident 57 when asked if she underwent a smoking assessed and stated she could not say if she was assessed for safety to smoke.</p> <p>A review of the facility's policy titled, Subject: Resident assessment (MDS 3.0), dated effective 1/20/16, and reviewed 2024, indicated purpose was, to assess each resident in a timely manner and provide care appropriate to the resident's needs from admission to discharge .within fourteen (14) or eight (8) days of the resident's admission, a comprehensive assessment of the resident's needs will be made by the interdisciplinary team .the purpose of the assessment is to describe the resident's capability to perform daily life functions and identify significant impairments in functional capacity .information derived from the comprehensive assessment enables staff to plan care that allows the resident to reach his/her highest practicable level of functioning and includes .physical and mental functional status .including determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>27532</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan for six (6) of six (6) residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 57) within 48 hours of their admission. This failure can impede continuity of care, cause uncertain communication among facility staff, and render them unprepared for adverse events that might occur right after the residents' admission as well as keeping the resident or representative in the dark of the initial plan for delivery of care and services.</p> <p>Findings:</p> <p>During a review of records on 2/29/24 at 4:30 PM, no baseline care plans, signed by the residents or their representatives, were found among the facility documents. A request was made to the CNO.</p> <p>48660</p> <p>During an interview on 03/1/24 at 10 a.m. Licensed Nurse K (LN K) stated new residents signed documents in an admission packet. She did not know if a care plan was developed within 48 hours of admission. She further stated she did not know if residents or their Resident Representative, RR (an individual chosen by the resident or authorized by law to act on behalf of the resident to support decision-making) acknowledged or signed for receipt of a baseline care plan.</p> <p>During an interview on 03/1/24 at 10:30 a.m., the Chief Nursing Officer (CNO) discussed the admission process for new residents. She confirmed there was not a Baseline Care Plan developed within 48 hours of admission. The CNO also stated there were no records of any care plans signed by new residents or their RR, if appropriate. She consulted with Health Information Management (HIM), and they were unable to find any documentation for 6 of 6 residents stating they received and signed for a Baseline Care Plan.</p> <p>A review of the facility's policies titled, Admission documentation requirements dated 9/26/19, and Resident care planning, dated 3/30/23, did not indicate or mention developing a baseline care plan within a resident's admission.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the regulatory Health and Safety Code S483.21 Comprehensive Person-Centered Care Planning, S483.21(a) Baseline Care Plans S483.21(a)(1) to S483.21(a)(3)(iv), indicated, the facility must develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . the baseline care plan should be developed within 48 hours of a resident's admission . include minimum health care information necessary to properly care for a resident including, but not limited to - Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASARR recommendations, if applicable .the facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: the initial goals of the resident, a summary of the resident's medication and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, any updated information based on the details of the comprehensive care plan as necessary.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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> 48660</p> <p>Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan for 5 of 6 residents (Resident 1, Resident 3, Resident 4, Resident 5, and Resident 57) to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. This failure had the potential to negatively impact the residents' quality of life as well as the quality of care and services received.</p> <p>Findings:</p> <p>A review of Resident 1's face sheet (demographics) indicated he was admitted to the facility on [DATE]. His diagnoses included Hypertension (a condition in which the force of the blood against the artery walls is too high), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear), Depression (a mood disorder that causes a persistent feeling of sadness or loss of interest), Type 2 diabetes (a health condition that affects how your body turns food into energy), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors).</p> <p>A review of Resident 1's Physician Orders included Sertraline with an indication for use: depression related to Parkinson Disease and Trazodone with an indication for use: insomnia and nighttime depression related to Parkinson Disease. Sertraline and Trazodone are psychotropic drugs (medications used to treat mental health disorders). Record review of documents for Resident 1, titled, Patient Care Plan, did not include a care plan for Psychotropic Drug Use for two of two psychotropic drugs.</p> <p>A review of Resident 3's face sheet (demographics) indicated a current admitted [DATE]. Her diagnoses included Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear), Depression (a mood disorder that causes a persistent feeling of sadness or loss of interest), Bipolar Disorder (a mental disorder characterized by mood swings ranging from depressive lows to manic highs), Diabetes (a health condition that affects how your body turns food into energy), and Hyperlipidemia (a condition in which there are high levels of fat particles in the blood).</p> <p>A review of Resident 3's Physician Orders included Risperidone with indications of use: depression associated with bipolar disorder, mania associated with bipolar disorder, and Sertraline with indications of use: depression and anxiety associated with bipolar disorder. Risperidone and Sertraline are psychotropic drugs (medications used to treat mental health disorders).</p> <p>Record Review of documents for Resident 3 titled, Patient Care Plan, did not include a Care Plan for Psychotropic Drug Use for one of two psychotropic drugs.</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 - Many</p>	<p>A review of Resident 5's face sheet (demographics) indicated he was admitted to the facility on [DATE]. His diagnoses included Coronary Artery Disease (damage or disease in the heart's major blood vessels), Hypertension (a condition in which the force of the blood against the artery walls is too high), and Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>During an interview and record review on 3/1/24 at 10:30 a.m., with the Chief Nursing Officer (CNO), the CNO stated she had been unable to locate any individualized care plans for Resident 5. She further stated she asked Licensed Nurse D (LN D) to develop care plans for Resident 5. Licensed Nurse D developed a set of individualized care plans for Resident 5, all dated 2/29/24.</p> <p>27532</p> <p>A review of Resident 4's admission Minimum Data Set (MDS - federally mandated clinical assessment tool of all residents' functional capabilities in nursing homes identifying health problems) indicated she is [AGE] years old, was admitted [DATE], for debility (state of being weak, feeble, or infirm) and/or cachexia (illness and characterized by muscle mass loss with or without fat mass loss), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities. Some people with dementia cannot control their emotions, and their personalities may change), malnutrition, adult failure to thrive (condition characterized by weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol) among other conditions.</p> <p>Further review of Resident 4's MDS indicated, care areas like cognitive loss/dementia and psychotropic drug use were among other care areas triggered during admission assessment. Care plans for these care areas could not be found among facility documents provided to the Surveyors.</p> <p>During a concurrent observation and interview on 2/27/24, at 8:44 AM, Resident 57 was smoking outside the facility with one of the security staff. Resident 57 stated she smokes every after meals outside the facility.</p> <p>During a concurrent review of records and interview on 2/28/24, at 8:27 AM, the Health Information Manager (HIM) came to assist the CNO generate reports and was requested Resident 57's care plan on smoking.</p> <p>During an observation of medication observation on 2/29/24, at 9:07 AM, Licensed Nurse H (LN H) administered one (1) 5 mg (milligram = unit of measure of mass in the metric system equal to a thousandth of a gram) tablet of Diazepam (a class of medication called benzodiazepine used to relieve symptoms of anxiety and alcohol withdrawal, may also be used treat certain seizure disorders and help relax muscles or relieve muscle spasm) to Resident 57.</p> <p>During review of records provided by the facility, Resident 57's care plans for smoking and Diazepam use could not be found among documents provided by the facility.</p> <p>During a concurrent review of records and interview on 3/1/24, at 9:25 AM, the CNO and Licensed Nurse K (LN K) acknowledged the care plans they just provided dated 2/29/24, were completed the night before.</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 - Many</p>	<p>A review of the facility policy titled, Resident care planning, dated effective 3/30/23, indicated, upon admission nurses gather data, input it into the electronic medical record (EMR) system and complete weekly summaries to generate data for the MDS. The MDS auto populate appropriate plans of care for each resident which are initiated and updated as needed by the MDS coordinator and nursing staff. The care plans are reviewed monthly by the Director of Nursing (DON). The policy further indicated; the date the care plan was initiated should reflect the date that the problem was identified.</p> <p>A review of the facility policy titled, Resident assessment (MDS 3.0), date effective 1/20/16, indicated, information derived from the comprehensive assessment enable the staff to plan care that allows the resident to reach his/her highest level of functioning. The policy further indicated, within seven (7) days of the completion of the resident assessment, a comprehensive care plan will be developed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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> 27532</p> <p>Based on observation, interview and record review, the facility failed to maintain an environment free from accident hazards and provide assistive devices to one (1) of six (6) residents (Resident 57) to prevent avoidable accidents. This failure had the potential to result in cigarette burns to Resident 57 and create a fire hazard to residents, staff and facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/27/24, at 8:44 AM, Resident 57 was smoking outside the facility by the roadside with one of the security staff. A portable ashtray was positioned by the right side of Resident 57's wheelchair. Resident 57 stated she smoked after meals outside the facility.</p> <p>During a concurrent interview and observation on 2/28/24, at 8:53 AM, Licensed Nurse B (LN B) stated Resident 57 smoked outside the facility after breakfast, lunch and dinner, and sometimes evenings when a staff is free. LN B stated Resident 57 had to be accompanied by staff during her smoke breaks. LN B stated the designated smoking area was 15 feet from the building, with fire extinguisher, and potable ashtray. LN B state Resident 57's cigarettes and lighter were kept in the Nurses' cart inside the locked medication room. Resident 57's family supplied the cigarettes. LN B Stated Resident 57 was a safe smoker, but when asked where Resident 57's smoking assessment was, he could not provide it and referred to the Health Information Manager (HIM)/Information technician (IT) to print the assessment. When it was mentioned that Resident 57 was observed not wearing an apron this date and on 2/27/24, LN B stated they have an apron if she needed it, but that Resident 57 is a low risk.</p> <p>During an observation on 2/28/24, at 9:02 AM, LN B was overheard asking the CNO where to find the apron for Resident 57's use.</p> <p>During a concurrent interview and observation on 2/28/24, at 09:21 AM, LN B brought the blanket that maybe used by Resident 57. When it was pointed out that it looked new, as the blanket was still wrapped in plastic, LN B stated it had not been used. When it was pointed out that the blanket looked flammable as it is made of [NAME] material, LN B stated he would provide documentation that indicated it was safe to be used.</p> <p>During an observation on 2/28/24, at 9:44 AM, the designated smoking area could be seen through the glass portion of the wall adjacent to the Emergency Exit door. The designated smoking area was about 3-4 meters or approximate 10 to 13 and half feet from the Emergency exit door. The blanket was still wrapped in plastic on top of the concrete wall by the fire extinguisher.</p> <p>During an interview on 2/28/24, at 9:55 AM, Resident 57 stated she was instructed to leave her cigarettes and lighter with the nurses, that she had to be accompanied by one of the staff during her smoke breaks. Resident 57 stated she could not recall if she was assessed for safety to smoke.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 2/28/24, at 1:45 PM, it was pointed out to the Engineering and Environmental Manager (E&amp;EVS Manager) that the fire extinguisher for their Designated Smoking area was approximately 3-4 meters from the Emergency exit door. The E&amp;EVS Manager stated he measured by steps the place where they positioned the portable ashtray by the roadside where Resident 57 smoked, which is more than 25 feet away. The E&amp;EVS Manager was told they must decide where their designated smoking area should be, should it be by the fire extinguisher attached to the fence wall opposite the Emergency Exit door or by the roadside where they positioned the portable ashtray.</p> <p>During an interview on 3/01/24, at 9:05 AM, when asked if the [NAME] blanket may be used as a protective apron when smoking, the Customer service representative of [NAME] Industries, who supplied the blanket proposed to be used by Resident 57 stated, the blanket was not customized to be used as an apron to protect the wearer from cigarette burns.</p> <p>A review of the product description of the wool blanket, proposed to be worn as protective material for Resident 57 indicated, the wool blanket could be used to keep shock victims warm or to smother clothing fires.</p> <p>A review of the facility policy titled, Smoking policy for in-patients and residents, effective 4/5/23, indicated, It is necessary that a written order to smoke be placed into the resident's chart by the physician, residents will be allowed to smoke in designated areas only, designated area will be 25 feet from all hospital and clinic entrances, exits, and open windows. The policy did not indicate the need to complete a smoking assessment of the resident's capabilities and deficits to determine whether supervision was required, or if adaptive equipment like a smoking apron, cigarette holder or other safety equipment was needed.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27532</p> <p>Based on interview and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>irregularities (refers to use of medication that is inconsistent with acceptable standards of practice, use without adequate indication, monitoring, in excessive doses, and/or in the presence of adverse consequences, etc.) noted by the pharmacist during drug regimen review (DRR) of two (2) of six (6) residents (Resident 1 and Resident 4) were documented on a separate, written report and sent to the attending physician and the facility's medical director and director of Nursing (DON) and lists, among others the irregularity that the pharmacist identified;</li> <li>the attending physician documented in the resident's medical record that the identified irregularity has been reviewed and any action taken to address it with a rationale for not agreeing with the recommendation; and,</li> <li>the pharmacist followed the different steps in the process of the DRR and the steps to be taken when he identified an irregularity that required action to protect the resident.</li> </ol> <p>This failure had the potential to result to unwanted, uncomfortable, or dangerous effects like impairment or decline in the residents' mental or physical condition or functional or psychosocial status, debility, or death of residents in the facility.</p> <p>Findings:</p> <p>During an interview on 2/29/24, at 9:94 AM, the Pharmacy Tech (PT) described his role in the management of pharmacy services in the facility. The PT stated the Pharmacy Consultant (CJ) came to the facility monthly to review each resident's medication. The PT stated the PJ had an excel spreadsheet documenting his reviews with recommendations and added he could print it and provide a copy to the Surveyors.</p> <p>48660</p> <p>A review of Resident 1's face sheet (demographics) indicated he was admitted to the facility on [DATE]. His diagnoses included Hypertension (a condition in which the force of the blood against the artery walls is too high), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear), Depression (a mood disorder that causes a persistent feeling of sadness or loss of interest), Type 2 diabetes (a health condition that affects how your body turns food into energy), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors).</p> <p>A review of Medication Orders printed on 2/29/24 at 10:18 a.m. indicated Resident 1 was prescribed Trazodone (Trazodone is an antidepressant medication used to treat depression and anxiety. It works by helping to restore the balance of a natural chemical in the brain) 100 mg (mg is a milligram, a unit of measure of mass in the metric system equal to a thousandth of a gram) on 7/12/23.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a printed Excel spreadsheet which documented the Pharmacist's monthly drug regimen review (DRR) had an entry for Resident 1 under the heading 1/2/2024. The document indicated trazadone taper recommended, action taken: Reported to DON, recommendation: REQUIRES URGENT CLARIFICATION, and was initialed by, ps.</p> <p>The facility was unable to provide any documentation or follow-up in regard to the Pharmacist's recommendation to taper Trazodone for Resident 1.</p> <p>A review of medication orders printed 2/27/23 at 8:32 PM, indicated Resident 4 was prescribed Quetiapine (Quetiapine is an antipsychotic medication - alters brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking) 25 mg (milligram = unit of measure of mass in the metric system equal to a thousandth of a gram) on 12/8/23.</p> <p>A review of the printed excel spreadsheet, without heading or official facility logo, indicated a tabulation of the Pharmacist's documentation of the monthly DRR, dated from 11/1/23 to 2/1/24. The tables have five (5) columns. Column 1 lists the names of the facility residents, column 2 contains notes of a combination of findings, action taken, and recommendations, column 3 with heading, Action and contained notes like, reported to DON, etc., column 4 with heading, recommendation, and column 5, without heading but contained the Pharmacist's initials. On the DRR, dated 2/1/24, and across the name of Resident 4, the PC wrote in column 2, consider lower Seroquel dose and in the of recommendations the PC wrote, review antipsychotic order. The PC did not document the irregularity he found and the reason for the recommendation to reduce the medication.</p> <p>During an interview on 3/01/24, at 10:47 AM, the PC confirmed he did the DRR monthly at the facility and reported his findings and any recommendations during the daily utilization review meetings. The PC stated he started sending his excel records to the DON since 12/2023. When asked how he was able to keep track and monitor whether his recommendations were acted upon, the PC acknowledged the need to improve his documentation and process of communicating the DRR and GDR recommendations to the facility.</p>		

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  03/01/2024
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 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>27532</p> <p>Based on interview and record review, the Governing Body (individuals such as facility owner(s), chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operation of the facility) failed to ensure to appoint a California Licensed Nursing Home Administrator (NHA) who was responsible for management of the facility. This failure had the potential to result in mismanagement and misguided care of the vulnerable residents and staff of the facility.</p> <p>Findings:</p> <p>During an interview on 2/26/24, at 4:09 PM, the Chief Nursing Officer (CNO) was requested a copy of the license of the facility Administrator. The CNO called the Administrator on her cell phone to check and requested for his Administrator's License. After speaking with the Administrator, the CNO stated, according to the Administrator, if this was not a hospital-based SNF, he would have to have an Administrator License, but it was not required for a hospital-based SNF.</p> <p>During an interview on 2/28/24, at 10:28 AM, when asked if he had an Administrator's License, the Administrator responded he did not have a license.</p> <p>During a review through the California Department of Public Health (CDPH) Licensure and Certification (L &amp; C) verification search page, the query for an NHA license confirmed the Administrator did not have one.</p>