

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/12/2025
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) worked at least 8 consecutive hours a day, seven days a week for a census of 8 residents. This failure contributed to staffing shortfalls: there were no RNs on duty for 7 days between January 2025 and March 2025, thereby creating the potential that residents would not receive RN-specific care such as assessments and intravenous medication administration. Cross reference F838. Findings: During a concurrent interview and record review on 9/11/25 at 4:10 p.m., the DON (Director of Nursing) reviewed the facility nurse staffing schedules dated, January 2025, February 2025, March 2025 and April 2025. The DON confirmed the facility did not have an RN scheduled to work on the following dates: 1/25/25, 3/1/25, 3/9/25, 3/16/25, 3/23/25, 3/27/25, and 3/30/25. The DON stated an RN who was working at the hospital on those dates was assigned to be a hospital float nurse (an RN who provides various duties including working different units like the Emergency Department or general hospital, assisting other nurses with tasks, covering nurses when they take a break, etc.). The DON confirmed the hospital float nurse was not specifically designated to work as an RN at the facility on those dates; the hospital float nurse was available to assist at the facility if needed. During an interview on 9/12/25 at 10 a.m., the DON stated the facility did not have a policy and procedure addressing staffing. During an interview on 9/12/25 at 12:11 p.m. with Quality Officer H (QO H) and Quality Staff I (QS I), QO H stated the facility was not aware staffing requirements were not met, as outlined in the Facility Assessment (comprehensive evaluation process assessing the resident population and the resources needed to provide competent care). The QO H stated they thought a float nurse was adequate. Review of the Facility Assessment titled, Facility Assessment Tool, dated updated 10/5/2023, indicated, . There is a Licensed Vocational nurse on each shift; 12 hour day shift and 12 hour night shift. There is a Resource Registered Nurse (float nurse) available 24 hours a day 7 days a week on site.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555516	Facility ID: 555516 If continuation sheet Page 1 of 8

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on administrative interview and record review, the facility failed to ensure a comprehensive facility-wide assessment (evaluation process assessing the resident population and the resources needed to provide competent care) was updated annually and included a staffing plan that ensured Registered Nurse's (RN) worked 8 consecutive hours per day, seven days a week. This failure contributed to staffing shortfalls: there were no RNs on duty for 7 days between January 2025 and March 2025, thereby creating the potential that residents would not receive RN-specific care such as assessments and intravenous medication administration. Cross reference F727. Findings: During an interview on 9/11/25 at 2:45 p.m., the Director of Nursing (DON) stated she did not have an updated facility assessment and provided a facility assessment tool dated, which was last updated 10/5/23. The DON stated the facility was currently working on updating the facility assessment. During a concurrent interview and record review on 9/11/25 at 4:10 p.m., the DON reviewed the facility nurse staffing schedules dated, January 2025, February 2025, March 2025 and April 2025. The DON confirmed the facility did not have an RN scheduled to work on the following dates: 1/25/25, 3/1/25, 3/9/25, 3/16/25, 3/23/25, 3/27/25, and 3/30/25. The DON stated an RN working in the hospital (located down the hall from the facility) was available to assist at the facility if needed but was not specifically designated to work at the facility. Review of the Facility Assessment titled, Facility Assessment Tool, updated on 10/5/23, indicated, . There is a Licensed Vocational nurse on each shift; 12-hour day shift and 12-hour night shift. There is a Resource Registered Nurse (float nurse; an RN who provides various duties including working different units like the Emergency Department or general hospital, assisting other nurses with tasks, covering nurses when they take a break, etc.) available 24 hours a day 7 days a week on site. During an interview on 9/12/25 at 10a.m., the DON stated the facility did not have a policy and procedure addressing staffing. During an interview on 9/12/25 at 12:11 p.m. with Quality Officer H (QO H) and Quality Staff I (QS I), QO H stated the facility was not aware RN staffing requirements were not being met, as outlined in the Facility Assessment (comprehensive evaluation process assessing the resident population and the resources needed to provide competent care). QO H stated they thought a float nurse (from the hospital) was adequate. QO H stated the facility did not have a policy and procedure for their Facility Assessment.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure professional standards of practice were conducted for two residents (Resident 3, and Resident 9) of eight sampled residents when insulin orders did not include blood sugar parameters (levels that indicate when blood sugar is considered too high or too low). This failure placed residents at risk for ineffective monitoring of insulin usage and worsening of their Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). Findings: During a review of Resident 3's untitled facility document indicated, the resident was a [AGE] year-old female admitted to the facility on [DATE], with a medical diagnosis that included DM. During a review of Resident 3's physician order report dated 5/28/25 indicated, Insulin glargine (a long-acting type of insulin used to manage blood sugar levels in people with diabetes) pen (a prefilled injection device containing insulin) 100 units/milliliter (specifies the concentration of insulin in one milliliter). Inject 20 units subcutaneously (a layer of fatty tissue just below the skin) at bedtime for DM. The order for insulin glargine dated 5/28/25 did not indicate parameters for blood sugar levels and when to notify a physician when the insulin was supposed to be held (not administered). During a review of Resident 9's History and Physical (H&P) dated 5/8/25 indicated Resident 9 was a [AGE] year-old- female admitted to the facility on [DATE] with a medical diagnosis that included DM. During a review of Resident 9's blood sugar flow sheets from 9/1/25 to 9/10/25 indicated, Resident 9 had episodes of fluctuating blood sugar levels between 236 mg/dl and 91 mg/dl (mg/dL, milligrams per deciliter, a unit of measurement for the concentration of blood sugar (glucose)). The medication administration record (MAR) dated from 9/7/25 through 9/10/25 did not indicate the frequency of monitoring blood glucose levels. During a review of Resident 9's Current Scheduled Medication report indicated, Insulin glargine pen, inject 80 units subcutaneously nightly for DM was ordered 5/20/25. The order for Insulin glargine did not show documented evidence that Resident 9 had an order for insulin parameters and when to notify a physician when the insulin was supposed to be held. During an interview and concurrent record review on 9/10/25 at 1:30 p.m., Licensed Staff K (LS K) reviewed the e-MARs (Electronic Medication Administration Record) for Residents 3 and 9 and confirmed their insulin orders did not have parameters. LS K stated the glucose checks and insulin parameters have not been ordered consistently for residents. During an interview on 9/11/25 at 11:15 a.m., Pharmacist J (PharmD J) stated parameters for insulin should always be ordered for insulin administration. PharmD J stated the standard of practice is for insulin to have parameters, or a sliding scale in the orders. PharmD J stated order-sets for insulin are used and sometimes discussed and reviewed with the physician. PharmD J stated he had not reviewed insulin parameters for Residents' 3 and 9 with the physician. During an interview on 9/11/25 at 2:25 p.m., Physician D stated his standard of practice for writing insulin administration orders included parameters for managing high and low blood glucose levels. Physician D confirmed the orders for insulin parameters were inconsistent and he was working on improving the processes. A review of the facility's policy and procedure (P&P) titled Insulin Utilization not dated, indicated, Insulin vials will be labeled with a patient specific label with insulin formulation, dose, directions for use and frequency. Two licensed Health Clinicians will verify the following prior to administration: the LIP [Licensed Independent Practitioner] order, type of insulin, dosage, route, time, and most recent blood glucose level. A review of The American Medical Directors Association's publication titled Diabetes Management in the Long-Term Care Setting revised 2010 indicated, A systematic facility approach to diabetes management can streamline day-to-day care and reduce the frequency of episodes of hypoglycemia [when blood sugar level is too low], hyperglycemia [when blood sugar level is too high], and other complications [of diabetes]. Make use of standing orders for glucose monitoring and practitioner notification when the patient is admitted. The practitioner may write an order stating that he or she is to be notified when a patient's blood glucose values are outside of a specific range. When (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patients are extremely frail or cognitively impaired and their blood glucose levels are poorly controlled, the practitioner may wish to note specific individual blood glucose or symptom parameters in the orders.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure Medication Review (MRR) policy and procedures were developed and maintained for scheduled medication reviews and oversight of medication administration. This failure put residents at risk for ineffective monitoring of medications and side effects that could go undetected by licensed staff and delay for the physician to act upon irregularities. Findings: During an interview on 9/11/25 at 11:15 a.m., the facility Pharmacist J (PharmD J) stated he had monthly MRR reviews for each of the residents and reported to the physician and Director of Nursing (DON). PharmD J stated during his MRR reviews he expected a response to any of his recommendations from a physician right away or within 48 hours. Pharm D J stated standard of practice for insulin administration included parameters and blood sugar checks in the orders. Pharm D J stated parameters should be ordered for residents depending on the type of insulin administered. Pharm D J also verified he did not review the residents that received insulin and if parameters were ordered. A review of the Policy and Procedures for the MRR process was requested, the PharmD J stated he was in process of writing the policy and procedures and currently did not have a policy and procedure for the MRR.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to ensure insulin pens stored in the medication cart were dated with an opened date for three residents (Resident 3, Resident 4, and Resident 8) of a sample of eight residents. This failure increased the facility's potential to administer expired medication and decrease the resident's opportunity to benefit from the full effect of the medication. Findings: During an observation of the Medication Cart and concurrent interview with Licensed Staff K (LSK) on [DATE], at 11:30 a.m., Insulin Pens (Insulin pens are convenient and discreet devices used to administer insulin for managing type 2 diabetes) did not have open dates for three residents. Resident 1's Lantus insulin pen was labeled with a beyond-use-date of [DATE]; Resident 2's Lantus insulin pen was labeled with a beyond-use-date of [DATE]; and, Resident 3 Humalog Kwik pen was labeled with a beyond-use-date of [DATE]. During a concurrent interview, (LS K) verified the insulin pens did not have an opened-date and stated once opened, an insulin pen use is for 28 days. During an interview on [DATE] at 11:20 a.m., the facility pharmacist (PharmD J) stated the insulin pens should be dated with an opened date. A review of the Institute for Safe Medication Practices article titled Storage of Insulin published 2025 indicated, Write the date you open the insulin on the product. On the day you open the insulin vial, pen, or cartridge, or start keeping it outside the refrigerator, write the date on the label. This will help you remember when to stop using it. Insulin expires 28 days after it is opened.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's two consulting Registered Dietitians (RD A and RD B) did not provide nutritional assessments and reassessments, per policy and procedure, for one resident (Resident 6) of eight sampled residents and the facility did not have documentation of an admission nutrition Nursing Care Plan (a document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) for Resident 6. These deficiencies caused Resident 6 to receive his first post-admission RD nutritional assessment almost two months later which potentially delayed the timely implementation of nutritional interventions designed to assist Resident 6 in attaining his highest practicable physical, mental, and psychosocial well-being. Findings: A review of Resident 6's hospital document titled, Initial Nutritional Assessment, dated 7/30/24 indicated the Registered Dietician A (RD A) had documented, . Low appetite reported. Intake: (less than) 25% . Under subtitled, Objective, RD A documented, Ht: (height) 5'9 (five feet, nine inches) Wt: (weight) 100 lbs. (pounds). Underweight status for ht/wt (height/weight) . RD to f/u (follow up) (in) 2-3 months of per consultation request. During a review of Resident 6's admission document titled History and Physical (H&P), dated 8/13/24 indicated Resident 6's diagnoses included Failure to thrive (substantial decline in overall health, including weight loss), Cachexia (significant weight loss and muscle loss), and Iron Deficiency Anemia (low iron causing decreased production of red blood cells.). The H&P also indicated Resident 6 was a candidate for admission to our long-term care facility for support with activities of daily living (basic tasks necessary for self-care and daily functioning like bathing, dressing, eating and toileting), physical therapy, and monitoring of nutrition. A review of Resident 6's initial MDS (resident assessment tool), dated 8/28/24, indicated he was admitted to the facility on [DATE], was 69 inches tall (approximately 5 feet, 7.5 inches in height), and weighed 105 pounds. The MDS assessment indicated Resident 6 triggered Nutrition, which indicated he should have a Nursing Care Plan to address his nutritional needs). Review of Resident 6's medical record titled, Follow-up Nutritional Assessment, dated 10/9/24 indicated RD A documented, .Ht: 5'9 Wt: 110 lbs. Underweight status for ht/wt. Weight gain about 10 lbs. in 3 months. RD to f/u 2-3 months or per consultation request. During a review of Resident 6's medical record, the Certified Dietary Manager (CDM, who was not a registered dietitian) documented in a CDM progress note on 8/22/24 that Resident 6's meal intake, .continues to be less than 25% . The CDM's next documentation in Resident 6's medical record was 10/9/24 (almost two months after his admission). A review of Resident 6's Nutritional care plan, dated 6/15/25, indicated interventions included, . Snacks between meals. Monitor weights and report significant weight loss. Dietary evaluation. Encourage nutritional supplements. During a concurrent interview and record review on 9/10/25 at 3:49 p.m., the Director of Nursing (DON), Director of Staff Development (DSD) and MDS nurse (a nurse who coordinates, assesses, and documents patient care in a long-term care or nursing facility using a comprehensive federal tool called the Minimum Data Set (MDS)) reviewed Resident 6's medical record. The DSD stated the CDM documented in Resident 6's medical record on 8/22/24. The DSD stated RD A's first documented assessment of Resident 6's nutritional status was on 10/9/24 and acknowledged the RD B had not documented in Resident 6's medical record between his admission on [DATE] and 10/9/24. The MDS nurse stated the facility did not have a nutritional care plan for Resident 6 prior to 6/15/25. During an interview on 9/10/25 at 5p.m., the CDM stated she had visited Resident 6, encouraged him to have Ensure (R) (a nutritional supplement), but she missed the fact he had no timely nutrition assessment. During a telephone interview on 9/12/25 at 9:39 a.m., RD A stated she worked as a consulting RD at the facility; she provided resident nutritional assessments remotely (she did not physically come to the facility). She stated she routinely did an initial nutritional assessment for new residents and then quarterly assessments thereafter. She stated if a resident was at high risk for nutritional issues she would reassess them every one to two months. RN A stated (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 6 should have had an initial assessment around 8/13/24. RN A stated she should have reassessed him after a month based on his weight of 105 pounds and diagnosis of Failure to Thrive. When asked why she hadn't reassessed him after a month, she stated she was not sure. During a telephone interview on 9/12/25 at 10:07 a.m., RN B stated she worked at the facility monthly for approximately two to three hours per month and her tasks included kitchen oversight and some resident education. She stated RN A addressed the majority of resident nutritional concerns; she stated she would only do a resident nutritional assessment if requested by RN A. RN B stated a resident who was 5 foot, nine inches tall, weighed 105 pounds and had a diagnosis of Failure to Thrive was a potentially high-risk nutritional resident. Review of facility policy titled, Nutritional Risk Screening and Assessment for . SNF (facility) Patients. undated, indicated, . Initial Assessment: . A nutritional assessment will be completed by RD within one week from admission. Reassessment. The RD will reassess patient within 1 week of consultation. Consultation could be triggered by and of the following: .If the patient is consuming less than 50% of food offered for 5 or more days.		